

# TASMANIAN WOUND CARE ASSOCIATION



[www.twca.com.au](http://www.twca.com.au)

March 2006

## DEEPES TISSUES

**WELCOME** one and all to the current TWCA Newsletter. Hope this publication finds you well and wound savvy. If you have any items you would like published in the newsletter, please submit to Carol on 62 228322, 0408 992 403 or e-mail [carol.baines@dhhs.tas.gov.au](mailto:carol.baines@dhhs.tas.gov.au)



The beginning of the year has been an exciting build up to the AWMA conference which was held in Canberra 15-16-17<sup>th</sup> of this month. This biennial gathering provides an essential forum for the exchange of information and a great opportunity to catch-up with colleagues.

Prior to the conference we were lucky to have two of the trade sponsored speakers present here in Tasmania. Molnlycke brought Helen Hollinworth to both the north and south of the state. Helen gave a comprehensive summary of her work in dressing change pain experienced by the patient and some fascinating insights into reducing this.

KCI introduced us to the 'fast talking lady with big hair from Nebraska' Susan Mendez -Eastman. Susan had an exciting presentation about the use of VAC and some very useful hints to its success in many applications of patient care.

All the education sessions were well attended and enjoyed thoroughly.

### **THE WATERLOW SCORE CARD**

The new Waterlow card is a handy pocket aide that Judy Waterlow has developed to include the Australian Malnutrition Screening Tool, MST<sub>1</sub>. The MST was developed by a team from the Centre for Public Health Research, Queensland University of Technology Brisbane, the Nutrition Services Dept. of The Wesley Hospital, and the Nutrition and Dietetics Dept. of the Radcliffe Hospital.

Although the original Waterlow tool included an area for appetite assessment, Waterlow herself states she had become even more convinced of the importance of nutrition in assessing risk factors for pressure ulcers.

The card is accompanied by a pressure ulcer prevention manual which assists with the use of the tool.

The card and manual are available for purchase at -

[www.judy-waterlow.co.uk](http://www.judy-waterlow.co.uk)

Waterlow encourages any groups or health services who would like to bulk buy for their employees to contact her directly.

1. Ferguson M., Capra S., Bauer J., *Development of a valid and reliable malnutrition screening tool for adult acute hospital patients*. Nutrition Vol 15, No 6, 1999.

More information can be obtained from Maree Ferguson [mferguson@wesley.com.au](mailto:mferguson@wesley.com.au)



# Australian Wound Management Association Inc

## Summary of AWMA Committee Meeting 19 & 20 November 2005

### **Open Forum: Inaugural Venous Leg Ulcer Consensus Meeting**

Over 90 people attended the AWMA's Open Forum Inaugural Venous Leg Ulcer Consensus Meeting in Perth on 6 September, 2005. The attendees were representative of nursing, medical, allied health, industry and consumers with a special interest in leg ulcers. A synopsis of the meeting including the consensus statements will be available on the AWMA website shortly.

### **AWMA Constitution**

A postal referendum of the entire membership was conducted allowing all members an opportunity to review proposed changes to the Constitution. The results, which have been posted on AWMA website, were in favour of adopting the revised Constitution. The AWMA is now working within the framework of the revised Constitution.

### **AWMA Fellow**

The AWMA Fellowship Award has been developed to recognise people who have made an outstanding contribution to the AWMA, and wound management in the Australian and Asia Pacific regions. A presentation to the Inaugural AWMA Fellows will occur on Friday 17 March 2006.

### **Paul Hartmann / AWMA Advanced Wound Care Scholarships**

Nominations for these Scholarships, one to be awarded in each State/Territory, closed on 30 December 2005. The Committees of each Association in conjunction with the AWMA Education Subcommittee have determined the successful applicants. Winners of these Scholarships will be announced at the AWMA Conference in Canberra 2006. This is an exciting opportunity for AWMA to join with Paul Hartmann to further knowledge of wound management at an advanced level in Australia.

### **APUAP**

The AWMA has formed a subcommittee to progress appointments of Chairs to the APUAP (Australian Pressure Ulcer Advisory Panel). The AWMA aims to announce and present the successful Chairs (Governance, Policy, Education and Research) at the AWMA Conference in Canberra March 2006.

### **National Institute Clinical Studies**

Ongoing negotiations are continuing as to how the AWMA may collaborate with NICS in supporting a NICS Fellowship in wound management.

### **AWMA Conference May 2008**

Planning will commence shortly for the 2008 AWMA Conference which will be hosted by the AWMA in Darwin, Northern Territory 7-10 May 2008. The theme of the Conference is 'Evolving Landscapes: Dreams, Diversity, and Disasters'. The objectives of the Conference are to assist the Northern Territory to establish itself as an independent branch of AWMA and to generate additional income that will allow the AWMA to expand the services it provides to the community.

## **THIS MONTH'S TWCA WEB SITE**

**Wound Biotech <http://www.bu.edu/woundbiotech/index.html>**

This site has lots of very interesting photographs on subjects such as the wound healing process, general wound care, bioengineered skin and growth factors. Well worth a browse.

## WOUNDS AT WORK



Sue works one day a week in wound management at Hobart based plastic and reconstructive surgery practice. She is the Tasmanian State Representative on the Australian Wound Management Association (AWMA) committee.

Sue runs Catalyst Training Solutions, a small business specialising in the delivery of clinical and corporate training for Health Professionals in Tasmania. She has a particular interest in wound management and pressure ulcer prevention.

Sue's interest in wound management began whilst as an orthopaedic clinical teacher at the Austin Hospital in Melbourne, she and a colleague attended a seminar conducted by Geoff Sussman and Donald McLellan in 1992. These inspirational speakers, as they still do, inspired Sue and her colleague to form an internal wound management committee to standardise wound management in the organisation and to get the moist wound healing message to the 'masses'. Implementation of a formal wound management education program in the hospital resulted in marked improvements in wound healing and pressure area reduction rates; alongside a dramatic measurable reduction in wound management consumables. In 1999, whilst delivering wound management education for the NSW College of Nursing, Sue was invited by the University of Cape Town to take this concept to South Africa and establish and deliver an extensive national wound management training program. This program incorporated principles of moist wound healing, wound assessment, classification and correct use of dressing products, and pressure ulcer prevention, amongst others. Marked cost savings throughout the health care system, improved healing rates, and a reduction in pressure ulcer incidence was again achieved through this program over a period of two years.

Sue has the firm belief through these experiences that education is the key to success in improving wound management outcomes, and this belief was the 'catalyst' for establishing her business. Hence the business name.

## WOUND TALK

Brought to you by Lotta Mank our roving reporter.



Dear Lotta

I have recently seen hydrogel dressings being used by nurses on skin grafts seven days post operatively. Can you comment on the efficacy of this?

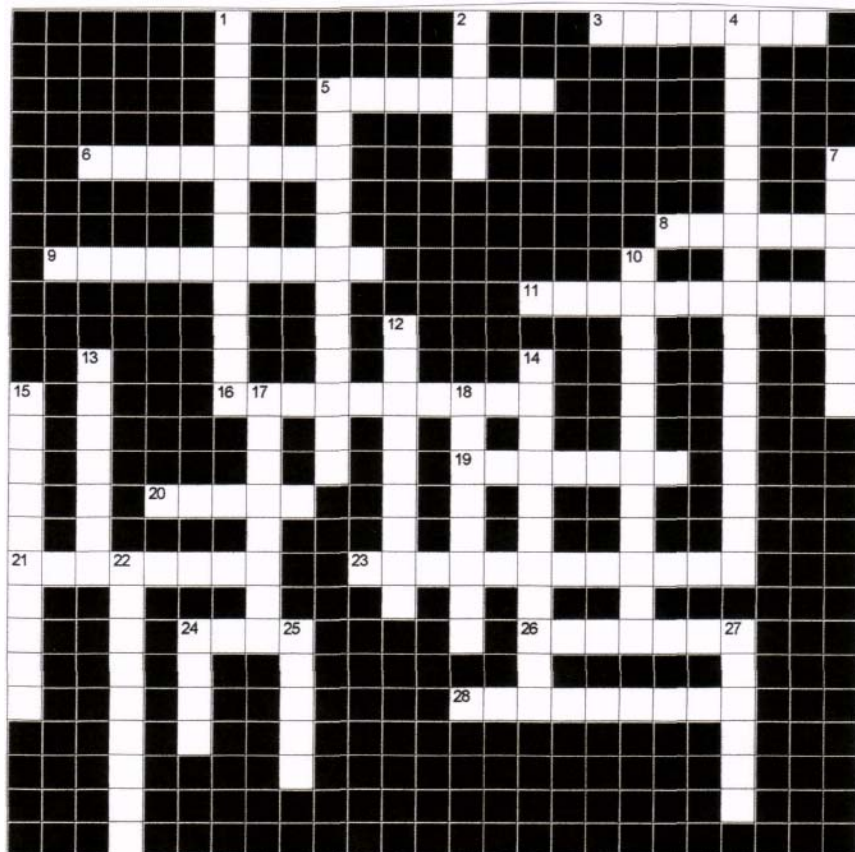
Jane

Dear Jane

Split thickness skin grafts need to be protected from moisture until they are completely taken as maceration will result in graft loss. Hydrogels and hydrocolloids will result in the graft being exposed to too much moisture and are therefore inappropriate post operative dressings for split thickness skin grafts. Appropriate post operative dressings include foams or non adherent contact dressings such as Adaptic (not traditional paraffin impregnated gauze as this is NOT non adherent) or Mepitel. These non adherent contact dressings will require a secondary dressing such as gauze.

Once the skin graft is completely taken, it will only require the application of moisturiser twice a day. The area should also be protected from shear and friction for a period of twelve weeks.

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### Across

3. Important nutritional component for wound healing
5. Test used to identify infectious organism of a wound
6. Dressing type that adds moisture to wounds; good for bums and painful wounds
8. Solution used for most wet-to-dry dressings
9. Inflammation of connective tissue
11. Term used when the body tries to stop bleeding by initiating coagulation after an acute injury
16. Separation of wound edges
19. Wounds that have failed to go through the repair process in a timely and orderly way
20. Wound type that follows the healing cascade in a timely and orderly process
21. Dressing type that absorbs large amounts of exudate; made from seaweed
23. Place a sterile saline-soaked dressing over loops of bowel when this occurs
24. Dressing type that adds thermal insulation to a wound
26. Too much of this causes maceration of the wound surface and surrounding tissue
28. Type of debridement that uses natural wound fluids to soften eschar

### Down

1. Dressing type that maintains moist environment in partial thickness wounds
2. Popular in the past as both primary and secondary dressing product
4. Method by which the wound surface closes
5. When increasing bacterial burden delays wound healing
7. Any of various materials used to cover, heal, and protect a wound
10. Term used to describe when a wound contains low levels of bacteria
12. Dressing that prevents exposure of the wound to air
13. What you fill a wound cavity with
14. Removal of necrotic tissue
15. Hardened formation
17. Redness
18. Death of tissue
22. When bacteria have invaded the tissue, are reproducing, and are causing a host reaction.
24. Dressing type used for wounds with little exudate; impermeable to water and microorganisms
25. This type of dressing should serve as the standard in wound care
27. Black dry necrotic area of a wound

**ANSWERS WILL BE PUBLISHED IN NEXT NEWSLETTER.**

## **CHRONIC PRE TIBIAL ULCERATION**

### **Bebe Brown - Diving and Hyperbaric Medicine Unit – Royal Hobart Hospital**

Mrs J, a 54 year old single lady, who lives alone presents with a five year history of a pre-tibial ulcer related to a minor trauma. She currently demonstrates good mental, emotional and general physical health.

Past history is complicated and includes: renal transplant following renal failure secondary to reflux nephropathy (1988), ex-smoker, previous excessive alcohol intake, hyperlipidemia, hypertension, gastro-oesophageal reflux disease and gout.

Current medications are Prednisolone and Sirolimus as immunosuppressant therapy, Atorvastatin, Ranitidine and Atenolol. She has no known drug allergies.

Mrs J's wound began as a minor pre-tibial graze from a rock whilst swimming in a creek. The wound was on the anterior aspect of the lower left pre tibial region. The wound on assessment consisted of a distal and a proximal wound bed – refer Figure 1. The distal area was 32sqcms and the proximal area 15sqcms – both wounds were superficial in depth. There was no obvious odour to the wound, the skin edges were good, exudate was minimal and the surrounding skin in good condition with small areas of dryness apparent. Histopathology from the wound showed non-specific granulation tissue and scarring. There was no evidence of malignancy or vasculitis. Gram positive cocci were found on gram stain and on culture *Staphylococcus aureus* had a moderate growth. On examination of ankle brachial index (ABI) findings, Mrs J had good blood supply to the left lower limb with an ABI of 1.3.

Initially the wound was treated conservatively. Over the next two and a half years she went on to have 3 split skin grafts to the ulcer - all of which failed. The most recent graft was in July 2005. Application of a V.A.C. dressing was instigated on two separate occasions. Mrs J had spent a total of eight months as an in-patient along with two years of continual community nurse support prior to her referral to the Diving and Hyperbaric Medicine Unit (HMU) at the Royal Hobart Hospital (RHH).

Following a referral from the plastic surgery team of a regional hospital Mrs J's initial presentation to HMU involved a full medical assessment and examination. Included at this time was tissue oxygen tension monitoring. Transcutaneous oxygen pressure (tcpO<sub>2</sub>) is a non-invasive method and its measurements have been shown to correlate with wound healing<sup>1</sup>. Measurements are taken on the area surrounding the wound and not directly on the wound surface. Roth and Weiss (1994)<sup>2</sup> consider that tcpO<sub>2</sub> greater than 20mmHg in room air predicts a positive response to hyperbaric oxygen (HBO). Refer Figure 1 for Mrs J's tcpO<sub>2</sub> measurements at 1ATA breathing both room air and 100% O<sub>2</sub> via a closed system.

Hyperbaric referral was undertaken as a last option for Mrs J and the decision was made that she would initially undergo 40 treatments – 8 weeks, 5 days per week. The treatment table used on a daily basis at the RHH HMU for wound healing is two hours in length at 2.4ATA. 100% oxygen is breathed via a closed hooded circuit during this time. In brief, hyperbaric oxygen increases the capillary oxygen tension which increases the amount of oxygen available to advancing cells of a wound. These cells are able to migrate further and retain the ability to divide. This enables the vascular supply to advance more quickly, thus ensuring faster closure of the wound. With large wound beds where closure is not complete the foundation is laid for successful skin grafting.

Mrs J has undergone 25 HBO treatments. Figure 2 shows the wound at this stage. The wound is notably smaller, clean with minimal slough, the edges pink and obvious granulation present. TcpO<sub>2</sub> measurements repeated at this time show a marked improvement. Further grafting is a possibility after 40 hyperbaric treatments

In summary, Mrs J is a 54 year old lady with a complex past history who sustained a small pre-tibial graze that did not heal with conservative treatment. Over a period of two and a half years this wound developed into a large chronic non-healing ulcer that impacted on her everyday life. During this time she had 3 failed skin grafts and two attempts at V.A.C. closure. Hyperbaric oxygen treatment was one of the last options available. Currently the plan is to re-vascularise the wound bed with an 8 week course of hyperbaric oxygen and then review her progress. Complete closure of the wound may then be achieved by a split skin graft.

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<sup>1</sup> *Textbook of Hyperbaric Medicine 3<sup>rd</sup> Revised Edition*. K.K. Jain, 1999. Chapter 14, p218. Hogrefe & Huber Publishers Inc. Germany

<sup>2</sup> Roth RN, Weiss LD, (1994) Hyperbaric oxygen and wound healing. *Clinics in Dermatology*, 12:141-156.



The wound at initial assessment



The wound following 25 hyperbaric sessions

## **CLINICAL UPDATE**

### **NORTH WEST – FRIDAY 21 APRIL**

**Venue:** Furner's Hotel – 42 Reibey Street Ulverstone  
**Time:** 2.00 – 4.00 p.m. or 6.00 – 8.00 p.m.  
**Cost:** \$20.00 Members \$40.00 Non-members  
~ Refreshments provided~

### **LAUNCESTON – SATURDAY 22 APRIL**

**Venue:** City Mill Business Centre – 76 York Street Launceston  
**Time:** 11.00 a.m. – 2.00 p.m.  
**Cost:** \$25.00 Members - \$45.00 Non Members  
~ Light lunch provided~

**Secure your place by booking with the ANF  
6223 6777 or toll free 1800 001241**

**BOOKINGS ARE ESSENTIAL**

*All items featured are submitted with the philosophy of improving wound care for sufferers and carers. No financial support is given or offered by wound care product manufacturers or distributors in the making of the newsletter. If you have any concerns or questions about items featured, please contact either:*

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