Pressure ulcer on the right lower limb

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Introduction

The patient suffers from a neuro degenerative disorder, which ultimately leads to reduction in cognitive and motor skills. Pressure ulcer was present on the right lower limb.

Patient

A 28-year-old patient, immobile, blind and mute came into the emergency room with an increasing dyspnoea and oedema. As a secondary finding, a pressure ulcer was observed on the right lower limb which was triggered by continuous pressure from the wheelchair.

According to the patient´s parents, the pressure ulcer had been present for 8 weeks.

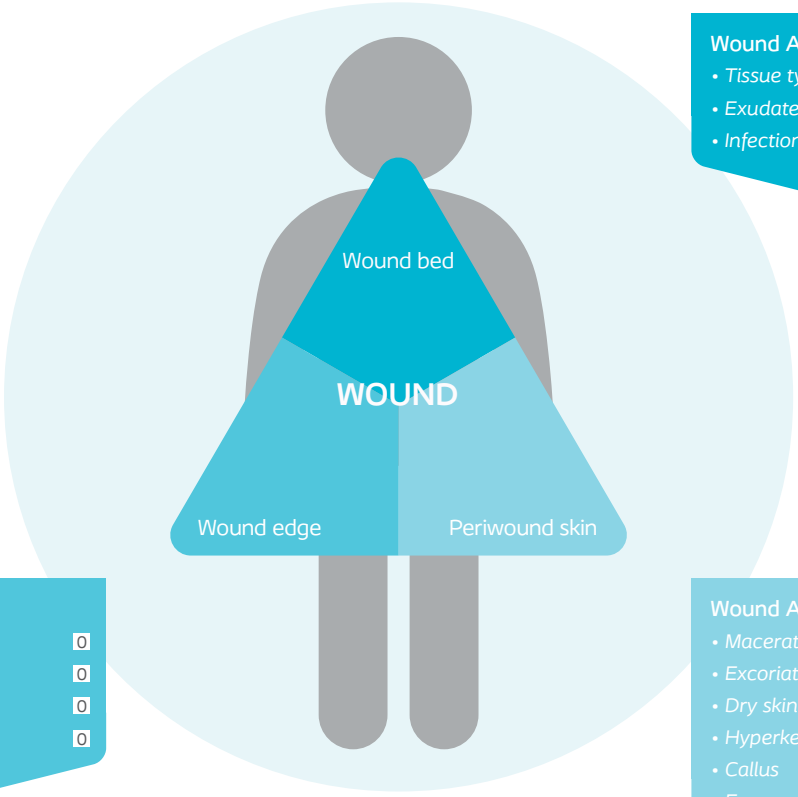
The previous treatment consisted of applying a silicone gauze to the skin necrosis and compression dressings.

Different methods of pressure relief had always failed.

Initial wound assessment

Size of wound	Length:	30mm
	Width:	30mm
	Depth:	10mm

For tissue type and exudate, write findings.
For others, mark "x" for positive findings from assessment, and mark "0" if not present.



Wound Assessment

- *Tissue type* Granulating
- *Exudate* Medium
- *Infection* 0

Wound Assessment

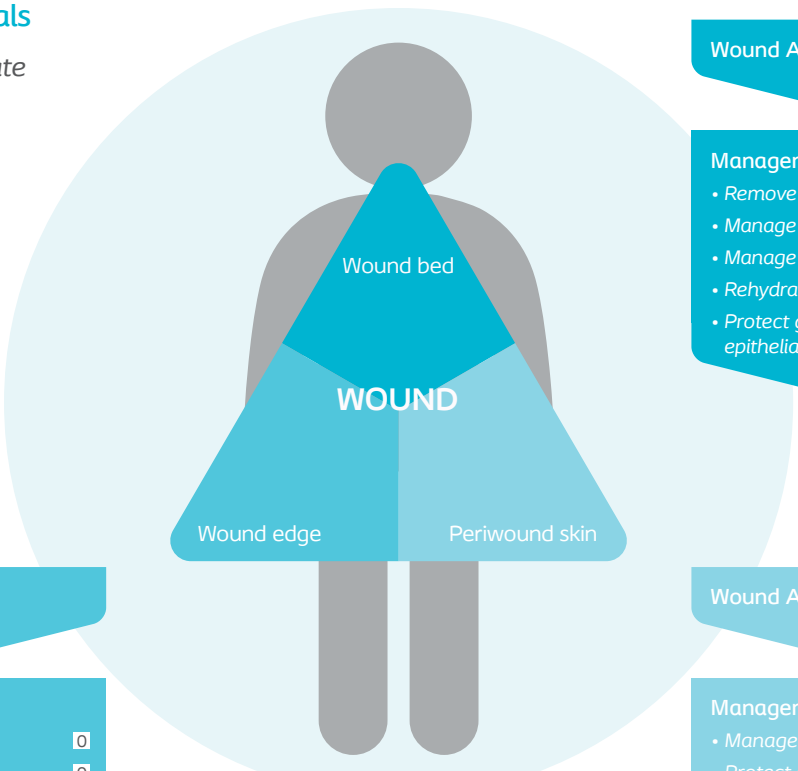
- *Maceration* 0
- *Dehydration* 0
- *Undermining* 0
- *Thickened/rolled edges* 0

Wound Assessment

- *Maceration* 0
- *Excoriation* 0
- *Dry skin* X
- *Hyperkeratosis* 0
- *Callus* 0
- *Eczema* 0

Management goals

Mark "x" for all appropriate management goals



Wound Assessment

Management goals

- *Remove non-viable tissue* X
- *Manage exudate* X
- *Manage bacterial burden* 0
- *Rehydrate wound bed* 0
- *Protect granulation/ epithelial tissue* 0

Wound Assessment

Management goals

- *Manage exudate* 0
- *Rehydrate wound edge* 0
- *Remove non-viable tissue* 0
- *Protect granulation/ epithelial tissue* 0

Wound Assessment

Management goals

- *Manage exudate* 0
- *Protect skin* 0
- *Rehydrate skin* X
- *Remove non-viable tissue* 0

Treatment

At the initial wound assessment, a black skin necrosis, about 3 cm in diameter, was removed.

A 10 mm deep wound cavity was formed. Wound cleansing with an antiseptic wound irrigation solution and application of Biatain® Silicone was initiated. As no signs of infection were visible there was no need for an antibacterial wound dressing. Initially, daily dressing changes was performed, this was related to the higher exudate levels. The dry periwound skin was rehydrated with barrier cream.

On day 7 of wound treatment with daily successive debridement, a 15mm deep wound was still present. There were recurring wound necrosis, which was removed at each dressing change. The wound diameter increased to 34mm. The level of exudate was reduced over time and the dressing change interval was changed to every second day.

On day 19 of wound treatment, a clean and necrosis free wound with granulation in the wound bed was observed. The wound depth was 12mm and the wound diameter 34mm. No maceration at the wound edge or periwound skin was observed. Initial oedema was significantly reduced by medication.

The dressing intervals was increased from day 24 to every third day. The wound depth decreased slowly and at the end of the wound treatment, the skin level was reached by granulation tissue forming in the wound bed.

On the 56th day of treatment, the diameter of the wound had been reduced by 8 mm. The wound depth was 0 mm with granulation tissue present.

Results

Intensive wound management lead to granulation tissue in the wound bed in a manageable time frame. No maceration of the wound edge or periwound skin was observed during the treatment. A wound filler was not used, as Biatain Silicone foam dressing very quickly conformed to the wound bed. The dressing protected the wound edge and the periwound skin from exudate and potential maceration. The attempts from the parents to get a pressure relief for the leg by different methods was not always successful.

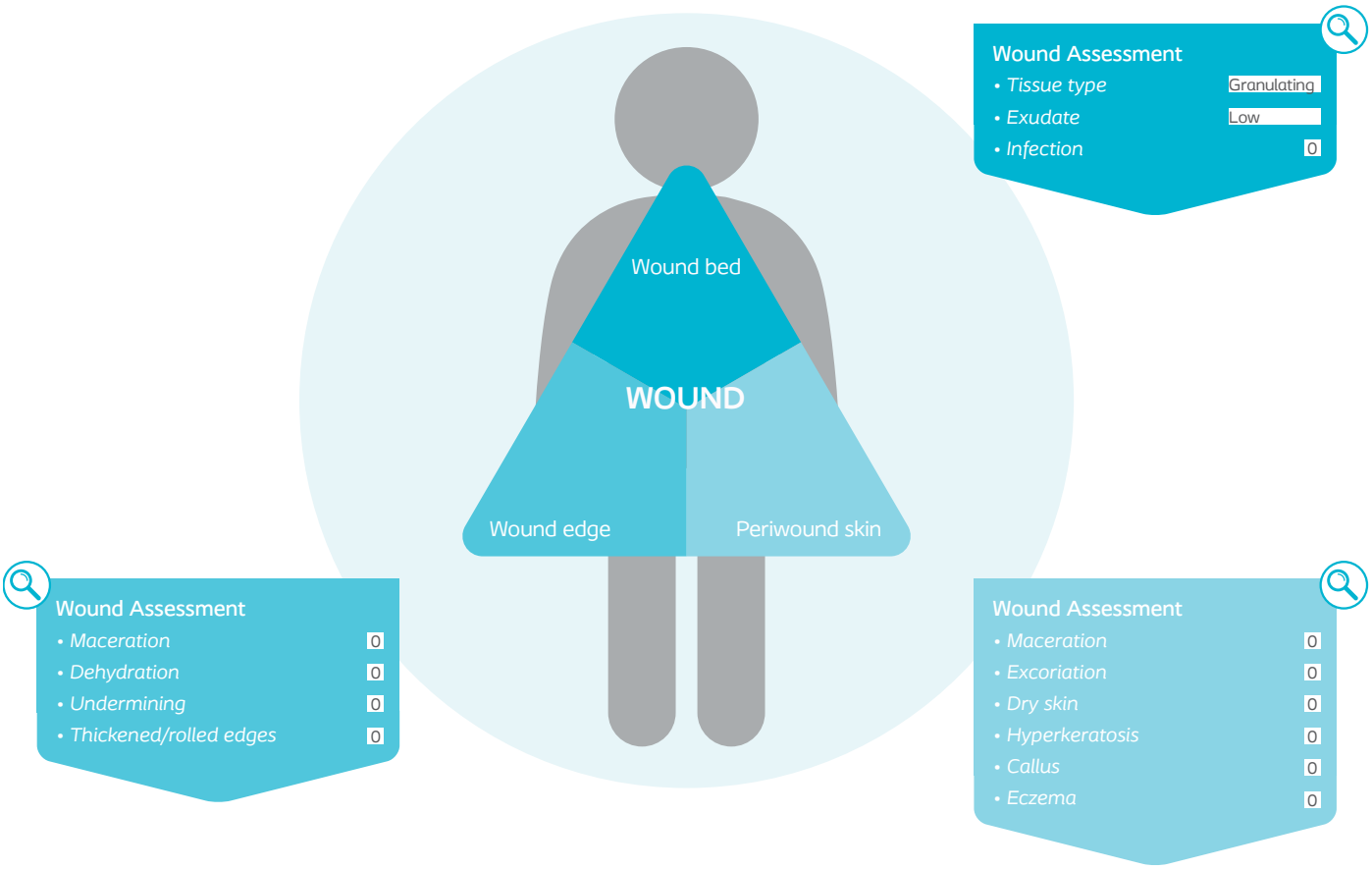
Day 7

Day 19

Day 56

Reassessment of the wound at the end of case period

For tissue type and exudate, write findings.
For others, mark "x" for positive findings from assessment, and mark "0" if not present.



Conclusion

Intensive wound treatment resulted in granulation tissue forming in the wound bed. Biatain Silicone managed the exudate very well and the dressings ability to conform to the wound bed prevented maceration of the wound edge and periwound skin.

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