ALLEVYN Life in the management of diabetic foot ulceration

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Background

Mrs W is a 63-year-old female with poorly controlled insulin-dependent diabetes, hypercholesterolemia and renal failure and has slept in her armchair for the past five years with her legs in a dependant position. Mrs W had recently been admitted to secondary care due to infection of a longstanding DFU to the lateral aspect of her left foot. During admission, surgery was performed to debride the devitalized soft tissue and amputate the 5th metatarsal along with the proximal, intermediate and distal phalanges. The post-operative wound was not closed, but left to heal via secondary intention.

Initial presentation

On initial assessment by the Tissue Viability Nurse the wound to the lateral aspect of her left foot measured 10cm x 7cm and 3cm in depth. The wound bed was covered by 70% fibrous slough with a small area of necrotic tissue to the lateral aspect of the wound. The remaining tissue at the wound margins was unhealthy pale pink, with no evidence of granulation or epithelialisation (see Figure 1). The wound was producing copious amounts of exudate which the District Nurse Team found challenging to contain, resulting in leaking into Mrs W's slippers. The skin had become macerated at the wound margins, and had become 'boggy' on the plantar aspect of the foot. The wound was malodourous, which was causing some distress to the patient and her daughter.

Factors affecting wellbeing

Physical Wellbeing

The leakage of exudate and the malodour were a constant reminder for Mrs W of the presence of her wound and the lack of progress. Mrs W expressed anger and frustration around some of the recommendations i.e. elevating her legs, going to bed. Mrs W experienced pain when the legs were elevated and felt more comfortable with her legs dependant.

Mental Wellbeing

Mrs W was disengaged, displaying signs of depression and anxiety related to her wound. During District Nurse visits the patient did not engage in conversation or enquire as to the progress of her wound. She had no interest in hobbies or social activities spending long periods alone at home.

Social Wellbeing

Mrs W had become socially isolated, with her only social interactions being during the visits by either the District Nurses or her daughter. Wound-related symptoms and poor mobility prevented Mrs W from being able, or wanting to go out with family or friends.

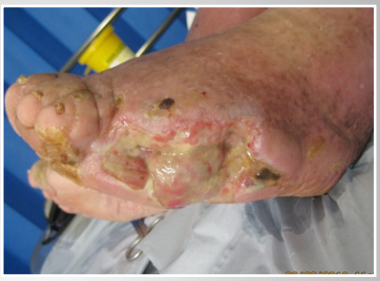

Fig 1. Appearance of the wound on first visit to clinic (9/8/2012)

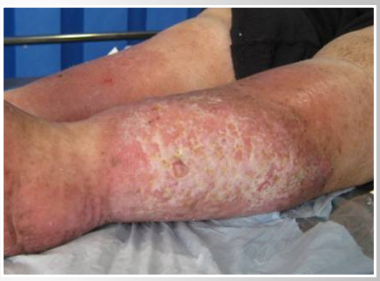

Fig 2. Lymphoedema of the limb

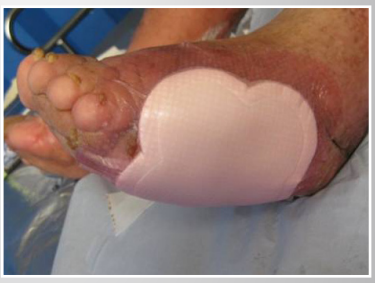

Fig 3. New dressing regimen

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Outcome

During the next eight weeks Mrs W attended clinic on a weekly basis. The frequency of dressing changes was reduced from daily to every three days after two weeks of the new treatment regimen following a reduction in the level of wound exudate coupled with the ability of ALLEVYN Life to manage what exudate was being produced effectively. The ability of the ALLEVYN Life dressing to both take up exudate and effectively mask it from view was also of great benefit to Mrs W for whom the presence of visible exudate within her dressings had previously served as a constant reminder of the presence of her wound.

The level of wound odour was greatly reduced and there was a considerable improvement in the condition of the wound bed which progressed to be covered with 100% granulation tissue with evidence of epithelisation at the wound margins (see Figure 4).

The most beneficial impact of the new dressing regimen for Mrs W was the reduction in odour and the fact that her slippers were no longer wet. Over the weeks the Tissue Viability Team were able to build up a therapeutic relationship with Mrs W who started to engage in conversation, sharing how she used to write poetry and loved to cook. Mrs W became more positive in her outlook and started to show an interest in how her wound was progressing, asking to see the photographs of her wound. Mrs W really enjoyed her clinic visits, and became a different person, chatting to other patients and becoming more involved in her care.

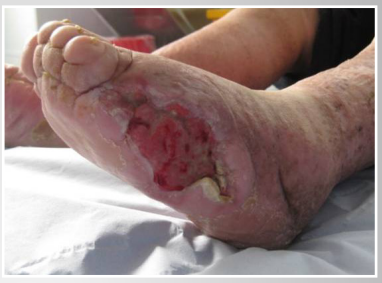

Fig 4. Maceration to the plantar aspect resolved, wound bed covered in 100% granulation tissue (25/9/2012)

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