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MANAGING ATYPICAL WOUNDS



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MANAGING ATYPICAL WOUNDS



Learning objectives

- Recognise when a wound does not fall into a typical wound category
- Understand wounds may not heal with dressings alone and may only be used to manage symptoms
- Understand the importance of onward referral for histology/investigation
- Recognise the need to work with various multi-professionals to manage symptoms as appropriate



What is an atypical wound?

- What makes a typical wound? Stages of wound healing!
- 20% of all chronic wounds are believed to be atypical
- 'An atypical wound can be suspected if the wound has an abnormal presentation or location, pain out of proportion to the size of the wound and does not heal within four to twelve weeks with a good treatment plan' (EWMA, 2019)

Self-harm



Picture ©DermnetNZ

- Incidence of deliberate self-harm is on the increase and ranges from minor superficial injuries to major trauma, such as genital self-mutilation and attempted suicide
- Individuals who self-harm tend to use more than one method over time
- Self-harm is an expression of emotional distress and can be seen as a distraction

Piercings/tattoos



Picture ©DermnetNZ

- Having a tattoo can often lead to minor inflammation. However, depending on the circumstances, there may also be a risk of infections and other types of reaction
- If a reputable, clean, licensed tattooist, who uses ink that is not contaminated, the risk of infection is low
- However, remember that by the mechanism of tattooing, the skin barrier protection is broken opening individuals up to the risk of cellullitic infections

Bullous pemphigoid



Picture ©DermnetNZ

- Rare autoimmune blistering disease. IgG autoantibodies bind to the skin's basement membrane in patients with pemphigoid disorders activating inflammatory mediators
- Autoantibodies attack the basement membrane causing subepidermal bullae



Differential diagnosis/considerations

- Blistering due to excess oedema in the tissue
- Burns
- Skin reaction/bullous drug eruptions
- Bites
- Friction



Differential diagnosis/considerations

- Herpes simplex/zoster
- Malignancy
- Bullous eruption of systemic lupus erythematosus
- Orf

Treatment

- Individualised treatment regimens to the patient
- Reduce blister formation and determine the minimal dose of medication necessary to control the disease process
- Promote healing of blisters and lesions
- Monitor patient progress until they are in remission, especially monitoring for signs of infection

Treatment

- Topical steroids and systemic anti-inflammatory medications
- Moist wound healing with silicone dressings to minimise further trauma on removal (e.g. Kliniderm[®] foam silicone)

Pyoderma gangrenosum



Picture ©DermnetNZ

- Rare autoimmune ulcerative skin condition of unknown aetiology. The name refers to ulcers with blue black edge, which progressively worsen
- Approximately half the people with PG have an underlying systemic disease, such as ulcerative colitis, Crohn's disease, chronic active hepatitis and rheumatoid arthritis
- Also consider first-degree relative with PG



Differential diagnosis/considerations

- Vasculitis
- Venous leg ulceration
- Malignancies
- Surgical site infection (SSI)
- Non healing trauma wound
- Infections — parasitic, bacterial, viral tropical mycoses, Orf

Treatment

- Correct diagnosis — specialist involvement
- Immunomodulatory therapy and/or immunosuppressant therapies
- Topical therapy
- Systemic therapy — pain!
- Wound therapy? Antimicrobials

Hidradenitis suppurativa



Picture ©DermnetNZ

- An inflammatory disease which primarily affects the hair follicles of apocrine gland bearing skin with recurrent lesions
- The lesions consist of inflamed and non-inflamed nodules, abscesses and draining or non-draining tunnels
- In later stages of the disease, scarring is prominent



Is HS a disease of wound healing?

- Chronic lesions characterised by a mix of inflammation and tissue damage in the form of scars, tunnels and occasionally hypertrophic granulation tissue
- Aetiology of HS largely unknown
- Chronic lesions in the later stage of the disease contain neutrophils and mast cells seen within surrounding tunnels containing an abundant biofilm

Treatment

- Multimodal, consisting of lifestyle changes and interventions — there is no cure
- Aim of medical treatment is to reduce disease progression and inflammation, thereby reducing pain and suppuration over time
- Challenging anatomically as usually occurs in peri-genital skin and axillae

Treatment

- Dressing selection needs to consider:
 - Absorbency
 - Anti-odour ability
 - Wearer comfort — soft and conformable
 - Silicone-based contact layer to prevent pain on removal (e.g. Kliniderm foam silicone)
 - Cost-effective products, as dressing changes may be frequent or performed by the patient

Calciophylaxis



Picture ©DermnetNZ

- Rare debilitating condition in which calcification of small and medium sized arteries (most commonly cutaneous and subcutaneous arterioles) occurs in patients with renal disease
- Calciophylaxis causes ischaemic necrosis of the dermis, subcutaneous tissue, muscle fascia and internal organs, leading to calcification of the soft tissues



Differential diagnosis/considerations

- Necrotising fasciitis
- *Pyoderma gangrenosum*
- Bullous pemphigoid
- Vasculitis
- Lupus erythematosus
- Erythema nodosum
- Covid-19! (Rotman et al, 2020) but you could see both
- Consider pressure ulcers

Rotman J, Dean K, Magro C, Nuovo G, Bartolotta R (2020) Concomitant calciphylaxis and Covid-19 associated thrombotic retiform purpura. *Skeletal radiology* **49**: 1879–84

Treatment

- Wound treatment should be initiated and monitored carefully
- Prevent further calcification occurring in soft tissues
- Prevent further skin breakdown
- Minimise risk of infection
- Prepare the wound bed for healing or skin grafting
- Antimicrobial hydrogel dressings, silicone foam dressings
- Prevent further ischaemia with bandages that are too tight

Necrotising fasciitis



Picture ©DermnetNZ

- Soft tissue infection that progresses rapidly, threatens limbs, causes shock and can also result in death
- The infection is usually of polymicrobial aetiology and may occur following surgery
- It is a necrotising infection involving any layer of the deep soft tissue compartment

Necrotising fasciitis



Picture ©DermnetNZ

- Fournier's gangrene
- Often misdiagnosed as cellulitis, deep tissue thrombosis, or an abscess



Differential diagnosis/considerations

- Cellulitis or erysipelas
- Erythema induratum
- *Pyoderma gangrenosum*
- Limb ischaemia, compartment syndrome
- Deep vein thrombosis (DVT) or thrombophlebitis
- Osteomyelitis with soft tissue involvement

Treatment

- Early diagnosis is essential for treating NF effectively
- Exploratory surgery and surgical debridement
- Intravenous (IV) broad spectrum antibiotics at high doses
- Intensive care unit admission for haemodynamic stabilisation

Treatment

- Preparation of the wound bed for healing and/or skin grafting
- Optimal wound healing is achieved with the use of advanced wound products that maintain a moist wound environment, absorb exudate, and minimise trauma on removal

Malignant wounds



Picture ©DermnetNZ

- Malignant wounds may be fungating or cutaneous
- The most common sites for malignant wounds include breast, neck, head and genitals
- Malignant wounds can include tumours that have fungated through the chest wall, for example, or be cancers, such as BCC, SCC or melanomas



Differential diagnosis/considerations

- Leg ulcers/injuries
- Parasitic lesions
- Seborrheic keratoses
- Dermatofibroma
- Radiotherapy skin reaction

Treatment

- Chemotherapy/radiotherapy/immunotherapy
- Manage the symptoms as they present — these can change daily
- Thorough holistic assessment — POSIES (pain, odour, skin infection, and self) (©Gardner and Taylor)
- Suitable wound dressings for the symptoms of the wound

Conclusion



- Early suspicion of an atypical wound and expert assessment is paramount in managing these complex wounds
- Watch and wait can have life-changing effects on how these types of wounds and skin presentations develop and progress
- Lack of consensus, evidence and guidelines make treating atypical wounds effectively very difficult

Conclusion



- Remember, full thorough holistic assessment to establish a clear clinical picture — don't just see the wound
- Lastly, dressings will not 'heal' the wounds, only manage the symptoms that these multi-system conditions present to us as clinicians

The Kliniderm range

The Kliniderm range includes **Kliniderm[®] foam silicone**, **Kliniderm[®] superabsorbent** and **Kliniderm[®] silicone wound contact layer**.

www.kliniderm.co.uk



The Kliniderm range

Kliniderm dressings^{1, 2}:

- Offer quality and savings without compromise
- Provide equal performance to market leading brands
- Offer a comfortable and gentle choice for patients



www.kliniderm.co.uk

1. Stephens C (2020) A 60-patient observational evaluation of the clinical benefits and acceptance of a silicone foam dressing for formulary inclusion within 5 NHS sites in the UK. Wound UK, poster.
2. Stephens C (2020) A 49-patient observational evaluation of the clinical benefits and acceptance of a superabsorbent within 5 NHS sites in the UK. Wound UK, poster.

Resources available

- Education modules — offering up to one hour of CPD
- Product brochures
- Patient information
- Clinical user guides
- Pathways
- Clinical evidence

For more information visit www.kliniderm.co.uk or email us at marketing@hrhealthcare.co.uk

kliniderm® superabsorbent dressing User guide

Kliniderm superabsorbent is a four-layer superabsorbent dressing held together by a hypoallergenic seal. Kliniderm superabsorbent is a protease modulator and is indicated for moderate to highly exuding chronic and acute wounds. Can be used effectively under compression.

Kliniderm superabsorbent removes excessive MMFs and exudate, provides moist wound healing, prevents maceration and excretion to the wound bed.

Where can Kliniderm superabsorbent be used?

Moderate exudate	Sloughy tissue	Dry wounds
High exudate	Under compression	Low exudate
Granulating tissue		Necrotic tissue

Where exudate is moderate to high.

Diabetic foot ulcers	Large cavity wounds	Small ulcers
Pressure ulcers	Infected wounds	Small cavities
Lig ulcers	Burns	
Surgical dehiscence		

Applying Kliniderm superabsorbent.

In the majority of instances Kliniderm superabsorbent may be applied directly to the wound bed as a primary dressing, thus ensuring optimum exudate handling capacity.

- Choose the appropriate dressing size which is slightly larger than the wound size
- Place directly to the wound bed as a primary dressing
- Secure in place with a suitable fastener i.e. tape, bandage or firm dressing

Exudate management with Kliniderm

Assess the patient and wound to identify any local, systemic, wound-related, environmental or psychosocial factors

Assess the volume of exudate and the wound bed

	Dry	Low	Moderate	High	Excessive
Description	Wound is dry No visible moisture	Small amounts of fluid are visible when the dressing is removed No per-wound maceration	Dressing may be extensively soiled Possible per-wound skin maceration/excretion	Excessive fluid is visible Primary dressing is wet and there may be seepage through or secondary dressing	Excessive fluid is visible Primary dressing is wet and there may be seepage through or secondary dressing
Management aim	Increase level of moisture Donate fluid	Maintain moist wound healing Maintain per-wound skin	Maintain moist wound healing Maintain per-wound skin	Reduce and manage the level of moisture Maintain per-wound skin	Reduce and manage the level of moisture Maintain per-wound skin
Dressing choice		Kliniderm® foam silicone lite	Kliniderm® foam silicone	Kliniderm® superabsorbent*	Kliniderm® superabsorbent*

Kliniderm® silicone wound contact layer**

*May be used under compression
**Use with appropriate secondary dressing

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kliniderm® foam silicone Mini Guide 3 Skin tears

For the prevention and management of skin tears

Skin tears are acutheumatic wounds which commonly occur in those with fragile skin, especially the elderly. They can result in partial or full separation of the skin's outer layers; the separation of the epidermis from the dermis (partial thickness wound) or both the epidermis and dermis from the underlying structures (full thickness wound). While not always avoidable, skin tears are generally considered to be preventable.

Using Kliniderm foam silicone on skin tears

Suitable for low to moderately exuding wounds.

Kliniderm foam silicone is an ideal dressing to use on skin tears as it's comfortable, facilitates flap security, easy to apply, can be on removal, protects the per-wound skin, controls exudate, maintains a moist wound healing environment and most importantly, avoids causing any further trauma to the skin.

When applying, remember to draw an arrow on the dressing to indicate the direction of removal from the anchored edge of the flap.

Hints and tips

- ✓ Use closure strips to approximate the wound edge
- ✓ Change secondary dressing on a regular basis
- ✓ Leave wound contact layer in place when re-dressing the wound for up to 14 days. The secondary dressing is changed based on wound exudate level
- ✓ Draw an arrow to show direction of removal of Kliniderm foam silicone dressings
- ✓ Monitor for further signs of breakdown
- ✓ Check for signs of infection at every dressing change
- ✓ Debride or provide additional dressings if the flap is non-viable - refer to Trust formulary
- ✓ Refer to a specialist if the flap deteriorates or there is no improvement
- ✓ Leave a 2cm overlap around the wound
- ✓ If the wound is healed, discontinue dressings and follow good skin care regimes.



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