THE USE AND EFFICACY OF MEDIHONEY® APINATE ON A LARGE, RECALCITRANT, INFECTED AND NECROTIC VENOUS LEG ULCER

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INTRODUCTION

Leg ulcers can be a challenge to heal especially when you are dealing with a patient with multiple co-morbidities and psychosocial issues. The patient in this case is a 51 year old male with current and historic use of IV drugs abuse. His current medical status is that he is HIV positive, Hepatitis C positive, currently on a methadone and in an alcohol abuse programme. He also suffers from asthma, heart failure, anxiety and depression. He remains an occasional IV drug user with a history of very high alcohol consumption and an inadequate nutritional intake.

This patient presented to his general practitioner (GP) on 21/3/16 with a grossly infected, malodourous wound on the left shin caused by IV drug use. The wound was 90% thick central necrosis and 10% surrounding green coloured infected slough measuring 10cm x 9cm. While depth could not be accurately measured, deeper tissue damage was suspected. Patient stated the wound present for 3 weeks. GP referred to Practice Nurse (PN) for dressings, but patient did not attend (DNA'd).

METHOD

Patient did attend a further appointment with PN on 24/3/16 and the wound was assessed and swabbed (Results-moderate *Enterobacter Cloacae*, *Staphylococcus Aureus* and Anaerobe isolated); a non- bordered foam dressing was applied. Patient was referred immediately to NHS Portsmouth CCG Leg Ulcer Nurse Specialist (LUNS) for assessment and advice. Doppler Vascular Screen was done next day (30/03/16), and results were within normal limits (ABPI 1.08) and all foot sounds were bi-phasic.

LUNS attended next apt on 05/04/16 and advised urgent sharp debridement by secondary care as necrotic area depth unseen and suspect of infection. The wound was too dry to consider larval therapy. A referral to surgical outpatients with appointment on 08/04/16 was made, but patient did not attend.

MEDIHONEY® Apinate was then instigated at LUNS suggestion on 15/04/16, cut to size and applied over all areas of the ulcer (slough and necrosis) to resolve infection, debride and reduce excessive odour. A sterile absorbent pad was placed over the apinate. (Odour was so offensive that patient found it unacceptable to be in company or wait in the surgery waiting room).

High compression inelastic bandaging was applied to support venous return, resolve oedema and aid autolysis. A barrier film was applied to peri-wound area. Two treatments of Apinate were applied in the first week which removed the necrotic 'plug' completely. This revealed a shallow, clean wound bed with some granulation tissue. Significant reduction in odour was noted. At next dressing (48 hours later) only 10% slough remained, so MEDIHONEY® Apinate was continued. Exudate levels had significantly reduced to 'moist from leaking'. Patient reported the pain was minimal.

RESULTS

Appointments were continued 2-3 times weekly as compression needed frequent reapplication. The wound remained clear of infection, slough and malodour with significant epithelisation at the wound margins (40-50% at 9 weeks) plus healthy granulation tissue across the rest of the wound bed. Patient reported no pain and improvement in quality of life due to odour elimination.

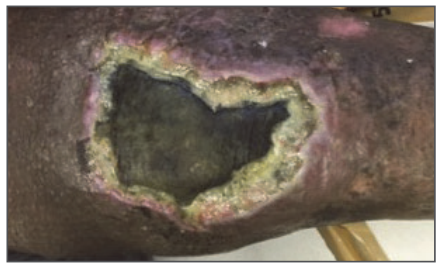
DISCUSSION

The appropriate use of honey was evaluated as a low cost and clinically effective anti-microbial, debriding agent and means to reduce significant malodour. MEDIHONEY® Apinate was chosen as an appropriate dressing to use on this patient. His trust and the support from his PN enabled her to maintain good levels of patient attendance to support timely dressing and bandage changes. This patient has subsequently become more confident and motivated to attend drug and alcohol rehabilitation that have been offered to him.

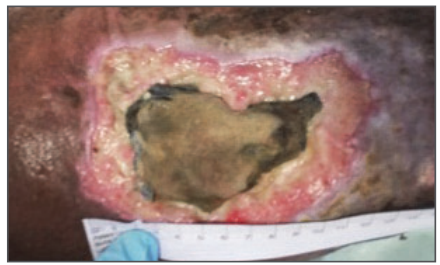
CONCLUSION

In spite of the significant co-morbidities, lifestyle issues, high levels of local wound infection/malodour/exudate/pain, the use of MEDIHONEY® Apinate provided a positive outcome in this complex wound case. The rapid progression to wound closure surprised all members of the team involved in his care. It also encouraged the patient to continue to attend regularly. This outcome has further impacted the patient to focus positively on resolving some of the other issues facing him in his current lifestyle.

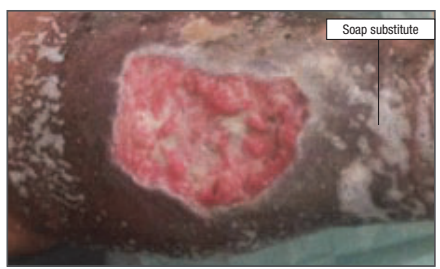
References: Dowsett C, Ayello E (2004) TIME principles of chronic wound bed preparation and treatment. *Br J Nurs* 13(Suppl 15): S16–S23



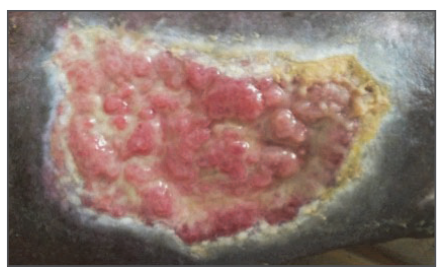
15.04.16



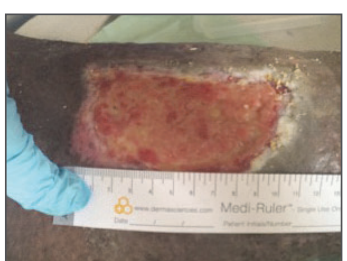
25.04.16- 1 week



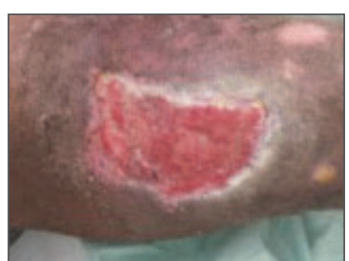
29.04.16 – 2 weeks



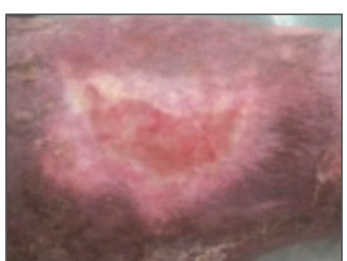
09.05.16 – 3 weeks



20.05.16 – 6 weeks



27.05.16 – 7 weeks



18.07.16 – 10 weeks