

Clinicians:

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Abstract: The AHCPR Clinical Practice Guideline, "Pressure Ulcers in Adults: Prediction and Prevention," stresses that individuals in bed who are completely immobile should have a care plan that includes the use of devices that totally relieve pressure on the heels, most commonly by raising the heels off the bed. Pressure ulcers of the heels are particularly challenging for the clinician. Classic signs of tissue breakdown, such as erythema and edema, are not always present or are camouflaged by opaque, dry skin. Simply elevating the heels off the support surface or bed is not always an option. For patients with anatomic anomalies or spinal cord injuries raising the heels may be contraindicated.

Case # 1: Prevention of Heel Ulcers

W.D. was a 51 y.o. male admitted with L1, L2 fractures following a fall while intoxicated. Information obtained from an acquaintance revealed a history of alcoholism, poor nutrition, and poor hygiene. The patient lived alone. He weighed in excess of 350 pounds on admission. For a short period of time he was placed on a rotational spinal treatment surface. Because of his weight, he developed abrasions over the axillary and upper thoracic area from the positioning pillows. He was switched to a foam mattress replacement. Air support surfaces were contraindicated due to the instability of the spinal fracture.

For any movement of the patient, logrolling was required. The head of the bed could not be elevated higher than 20-30 degrees. Pain in the lower back precluded elevation of the legs onto pillows to preserve skin integrity of the heels. He complained of severe tenderness in the heels yet there were no visible signs of tissue damage. The left heel was extremely tender on palpation. Slight edema was detected but no reactive hyperemia or pitting.

Elasto-Gel™ hydrogel sheet dressings were applied to each heel to cushion the bony prominence. Every three days the dressings were removed, the heels bathed normally, and a new gel sheet applied. The severe tenderness resolved with the first application of Elasto-Gel™. Treatment was continued for 11 days. At that time there was no pain or edema and the skin was healthy and intact with no evidence of tissue destruction.



5/27/87

The Heeling Touch

Prevention and Treatment of Heel Ulcers Using a Hydrogel Dressing



6/8/87



6/16/87

Case # 2: Treatment of Pressure Ulcers

S.S. was a female registered nurse and a fellow employee who called the ET Nurse to report a tender area on the left heel. Upon examination, the total wound area was 10 cm in size, partial thickness except in the center which was full thickness and 1 cm in size. There was light to no exudate, no edema, no necrosis, and total wound erythema. Probable cause of wound-insect bite. The wound was cleansed with a common wound cleanser and a thin coat of an amorphous hydrogel was applied. An Elasto-Gel™ hydrogel sheet was then placed over the wound site. This remained intact without a dressing change for 5 days.

On 10-10, the total wound area remained 10 cm in size. The center open wound healed from 1 cm to .5 cm and the surrounding skin was well on the way to being healed. The amorphous hydrogel was discontinued and a new Elasto-Gel™ sheet was applied.

10-12 Elasto-Gel™ sheet was removed, and the wound was healed, however, remained reddened. At this point she was able to leave the dressing off without feeling pain from the rubbing of her shoe. She was instructed to apply an amorphous hydrogel for one week to keep the area soft and reduce the reddened area.

The best part of using Elasto-Gel™ was that it gave her comfort. As a nurse manager, she was on her feet all day and Elasto-Gel™ allowed her to where her shoe and work.



10/5/89



10/10/89



10/12/89

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