ELASTO-GEL™ AS A DRESSING FOR INFECTED HERPES ZOSTER LESIONS

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A 70 year-old woman was referred to our home health agency by her internist physician after an office visit. The diagnoses were acute and chronic bronchitis, COPD, and herpes zoster with infected right hip lesions. Medications included Prednisone™ 30 mg. daily p.o., Methtrexate™ 5mg 3x a week, and Cipro™ 500mg. BID. The patient lived alone and there were no family members available to assist her with personal care or house keeping chores.

The patient's number one complaint was severe, excruciating, burning pain secondary to the infected herpes zoster lesions on both buttocks and right hip. The mucous membranes of her mouth and anus exhibited multiple painful white lesions. She also complained of dyspnea, fever, and confusion at night, which she interpreted as "bad nightmares". This steroid dependent, immunosuppressed patient reported that she has had "shingles" before and she had always been able to make the shingles go away with Calamine™ lotion, Vitamin E capsules, and hydrogen peroxide. She had been treating the present wounds for approximately 3 months at home.

Herpes zoster normally presents with a burning pain and then a rash that becomes vesicular and pustular. These vesicles are finally seen to erode and crust. In contrast to a normal outbreak of herpes zoster, this patient presented with a secondary infection and extensive tissue damage. There were approximately 14 wounds that ranged from Stage 2 to possible Stage 4. Sizes ranged from 0.25 cm^2 to 40.5cm^2 and from 1 to 3mm deep. Approximately 75% of the largest wound was filled with a black firmly adhering eschar on the right hip. The other wounds on the right hip, right and left buttocks, and coccyx were filled with yellow necrosis, and there was a small to moderate amount of pink and yellow cloudy drainage.

The Home Health nurse initiated daily visits for this patient. The wounds were treated with wet to dry saline soaked gauze dressings daily. This wound dressing proved to cause more pain as the dressing dried out and became stuck on the wounds. These dressings were held in place with paper tape. Inevitably, the tape would slip and get stuck to a lesion. The patient described her pain as excruciating when the tape was removed from a lesion.

Several problems needed to be addressed regarding appropriate wound care for this patient's infected herpes zoster lesions. First of all, the wounds needed a moist environment in which autolytic debridment could take place. Autolytic debridement was the chosen method because the patient was not a candidate for surgical debridement. A moist healing environment was also needed to promote granulation and epithlialization of the dermal wounds. Pain control was another important issue. A non-adhesive dressing was desired due to the patient's extremely sensitive skin.

Elasto-Gel wound dressings were selected. The patient expressed an immediate feeling of coolness and decreased burning sensation after the dressings were applied. The dressings were held in place by Se-Pro-Net. Two 12 inch pieces of size 8 Se-Pro-Net were used with a small "V" shaped cut approximately 4 inches from one end. These became like a pair of form-fitted leggings to hold the dressings on the buttocks and hip.

The physician ordered Silvadene Cream™ and it was found that Elasto-Gel wound dressing could be used in conjunction with this topical medication. It was felt that the combination of the Silvadene Cream™ plus the Elasto-Gel wound dressing would especially improve the debridement process of the eschar on the right hip.

Dressing changes were increased to BID due to the patient's increasingly compromised respitory condition, pain control issues, and general apprehensiveness. The Elasto-Gel wound dressing was reused for the BID dressing changes only. It was felt that due to the infected wounds, the patient's compromised immune system, and the use of Silvadene, the Elasto-Gel dressing would be replaced daily.

A verbal pain rating from "0" (no pain) to "10" (worst pain ever) was obtained from the patient before and after dressing changes. During the first week with Elasto-Gel wound dressing and Silvadene Cream™, the patient's average pain intensity rating before dressing change was "6". The average pain intensity rating immediately after dressing changed during this time was "3". By the end of the second week, the pain from the lesions was rated "2" before dressing changes, and "0" after dressing change. At the beginning of the third week, an attempt was made to decrease the nursing visits to once a day for dressing changes. Pain ratings increased to "9" before dressing change and "4" after dressing change. Because of increased discomfort, the visits were increased to BID again for dressing changes. At the end of the fourth week the nursing visits were decreased to once a day. At this time, the patient only referred to her wound discomfort as a little soreness but no pain. This soreness was relieved after a dressing change.

Within 3 weeks of initiating the Elasto-Gel wound dressing with Silvadene Cream™, the lesions on the buttocks and coccyx were healed leaving the deepest and most extensive lesions on the right hip. During the second month, the black eschar on the hip became soft and spongy so that the R.N. was able to remove the eschar with a scissors. All lesions were healed by the third month except for the most extensive wound on the right hip and this has continued to decrease in size and depth.

Micropore™Paper Tape was used to help secure the Elasto-Gel wound dressing in place after the patient's pain decreased. Bard skin protectant was applied to the skin wherever tape was placed and there were no complaints from the patient when the tape was removed. It was helpful to be able to use tape as the Silvadene™ caused the dressings to slide, and this became a problem as the patient became more active.

The Elasto-Gel wound dressing has definitely proved to be effective for debridement purposes, for promoting granulation, epithelialization, and for comfort and pain control in this patient with infected herpes zoster lesions.

Presented at the Symposium on Advanced Wound Care.
April 1992, New Orleans