

WOUND DEBRIDEMENT AUGMENTED WITH THE USE OF PANAFIL™ AND ELASTO-GEL DRESSING™

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CASE #1

A 63 year old white male with terminal metastatic colon cancer presented on 10/10/90 with a necrotic grade IV ulcer on the sacrum. Spinal metastasis at the lumbar region left him with no sensation at/or below the ulcer. The patient had a full leg amputation on the left due to a war injury. A fall caused a fracture of his right femur. Pain and traction left him fairly immobile. This was complicated by 4+ edema about and below the ulcer. Initially the ulcer measured 6x8x2cm and was very malodorous.

Our goal was to rid the ulcer of the necrosis and prevent sepsis which would further complicate his already fragile condition. A regimen of Chloresium™ solution wash, followed by application of a thin layer of Panafil™ ointment, and a cover with Elasto-Gel™ dressing provided several benefits. The Chloresium™ served to gently cleanse the wound and deodorize. The Panafil™ and Elasto-Gel™ enhanced autodebridement. The Elasto-Gel™ can be reused while the Chloresium and Panafil applications were done daily. On this patient, however, the Elasto Gel was changed daily because of the massive amount of fluid oozing from the wound.

Soon ABD pads changed two times a day replaced the Elasto- Gel™. As the wound was freed of necrosis it widened and deepened. The odor was very offensive. After cleansing with Chloresium™ solution, and application of Panafil™ ointment, fluffed 4x4 gauze dampened with Chloresium™ was gently placed in the wound for odor control. By December, six weeks after treatment had begun, the wound was nearly free of necrotic material. Regeneration of tissue was not likely in this deteriorating patient. More tissue eroded leaving the prominences of the coccyx bone exposed. The wound was kept clean and free of new necrosis until the patient expired in mid-January.

CASE #2

A mid-70 year old white male with multiple sclerosis, post CVA, with diabetes, developed a large sacral ulcer. He was placed on a Clinitron bed. Lack of turn allowed the wound to deteriorate. Surgical debridement was performed in late September. The wound continued to deteriorate secondary to pressure and drying from the constant flow of air. The wound measured 10x8x2cm deep and undermined approximately 4cm. Daily treatments were started using Chloresium solution washes, Panafil™ ointment, Chloresium™ solution dampened fluffed 4x4 gauze (to fill the wound deficit) and Elasto-Gel™ dressing.

Initially the Elasto-Gel™ dressings were changed one to two times a day because of fecal soiling. After implementing a fecal pouch, the Elasto-Gel™ dressings

were reused for three to four days. The wound remained moist because of the Panafil™ ointment which aided in debridement, the Chloresium™ damp gauze which also provided deodorization, and the moist occlusive Elasto-Gel™ dressing. The wound could be examined several times a day with no additional use of supplies.

By 11/14/90, the wound was free of necrosis. Undermining did not exist. The Chloresium™ and Panafil™ were discontinued. The wound now measured 9.5x8x0.5cm deep. The Elasto-Gel™ cover was changed every three to four days. By 12/5/90, the wound drainage decreased enough that the Elasto-Gel™ is changed weekly, though daily inspections were possible because of the reusability. By 1/30/91, wound contraction and epithelial migration were occurring. The wound measured 9x4.5x.25cm deep. The wound measured 6.5x3cm on 2/19/91. The patient could no longer be followed due to rehospitalization for pneumonia.

CASE #3

An 83 year old white female immobilized after a CVA suffered recurrent breakdown to the right ischeal tuberosity. The wound measured 4x4x5cm. Soft necrosis filled the center. Though ischemic, the edges were soft. Previous treatment was normal saline damp to dry gauze. On 10/24/90, Elasto-Gel™ dressing was started and changed once a week. Initially the wound responded to the moist occlusion. On 10/31/90, the necrosis was less and the wound edges showed evidence of granulation tissue. The wound began to worsen probably secondary to pressure. By 12/12/90, thick eschar was forming. At this point, Chloresium™ solution washes, Panafil™ ointment and Elasto-Gel™ dressing were implemented. Daily application of the Chloresium™ and Panafil™ were done, while the Elasto-Gel™ was changed one time per week.

One month later, on 1/14/91, much of the necrosis was removed, yielding a wound that measured 5x4x3cm deep. By 1/30/91, thin fibrin covered the base of the wound. On 2/7/91, the fibrin was diminished further. Healthy granulation tissue lined the walls of the wound, which now measured 4.5x3.5x2.5cm deep. Ther patient expired before healing was complete. The Elasto-Gel™ was cost effective in that it was only changed once a week, yet the wound could be inspected or treated on a daily basis. This is not possible with most other moist occlusive dressings.

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