CLINICAL CASE STUDIES UTILIZING HYDROLYZED COLLAGEN POWDER* TO EFFECTIVELY HEAL A VARIETY OF WOUNDS

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Abstract

Objectives:
1. After viewing this poster presentation the participant will be able to formulate an effective treatment plan utilizing a hydrolyzed collagen powder* to enhance rapid healing.
2. The participant will be able to describe two benefits of utilizing this relatively new product.

Rationale:
This absorptive, 100% hydrolyzed collagen product* was selected for its ability to stimulate fibroblastic activity as well as its ease of application.

Case #1:
A fifty-six year old diabetic, hypertensive, obese patient with large partial thickness undermined wounds of the buttocks. Wounds cleansed daily, hydrolyzed collagen powder* sprinkled on gauze dressing and applied to wound. Healed in thirty days.

Case #2:
A seventy-two year old diabetic, hypertensive patient with a five month duration non-healing post surgical wound of the left foot. Wound cleansed daily, hydrolyzed collagen powder* to wound bed, covered with foam. Healed in ten days.

Case #3:
A seventy-five year old obese patient with peripheral vascular disease and previous chronic slow healing leg ulcers. Partial thickness wounds of bilateral lower legs. Weekly cleansing of all wounds, filled with hydrolyzed collagen powder*, covered with foam dressing and compression wraps. Healed in eighty-five days.

Conclusion:
The hydrolyzed collagen powder* stimulated fibroblastic activity within one week and promoted healing in those vascular compromised wounds. Hydrolyzed collagen powder* requires non-physician application, was easy for the patient to apply, absorbed excess fluids effectively with comfort, and had great healing outcomes.

References
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Product used:
* Stimulen™ Collagen Powder

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Case #1:

A fifty-six year old obese hypertensive diabetic with a large partial thickness tunneling and undermining wounds of the buttocks.

Photo #1 (3-2-06): The patient presented to wound clinic with two connecting wounds on the buttock. The wounds occurred following the progression of a "sore rectal area" to open wounds draining copious amounts of foul smelling drainage. The patient sought medical attention and was placed on an oral antibiotic and referred to the outpatient wound clinic. Initial assessment of the wounds revealed partial thickness, connecting pale red wound beds. The proximal wound measured L 1.2 cm x W 0.6 cm with a depth of .9 cm. The distal wound measured L 3.4 cm x W 3.0 cm with tunneling of 5.5 cm.

Protocol: The patient was instructed to daily cleanse the areas during showering. Application of a silver hydrogel and covered with a gauze dressing.

Photo #2 (3-16-06): Distal wound measured L 0.9 cm x W 1.8 cm with a depth of 0.4 cm. 3 o’clock undermining was 0.4 cm and 9 o’clock undermining was healed. The proximal wound was healed, 100% granular and contracting. The distal wound continued to be beefy red with scant serosanguineous drainage.

Photo #3 (3-30-06): Distal wound measured L 0.9 cm x W 0.8 cm with depth of 0.2 cm. Wound presented with continuous slough and increased serosanguineous drainage. The wound now measures L 1.4 cm x W 0.6 cm with depth of 0.3 cm. Wound presented with continuous slough and increased serosanguineous drainage. Edges of the wound were macerated.

Protocol: Treatment was changed to apply an enzymatic debrider to the wound bed, skin barrier periwound and covered with a foam dressing daily.

Photo #4 (4-13-06): Distal wound healed with scar tissue formation after thirty days of initial treatment. There were no signs or symptoms of infection.

Case #2:

A seventy-one year diabetic, hypertensive patient with a five month duration, non-healing post surgical wound of the left foot.

Photo #1 (12-22-05): The patient presents with decreased serosanguineous drainage. The patient presents with increased edema and increased serosanguineous drainage, 50% granulation and 50% slough.

Protocol: Treatment was changed to apply an enzymatic debrider to the wound bed, skin barrier periwound and covered with a foam dressing daily. The patient presented with decreased serosanguineous drainage.

Photo #2 (1-5-06): Heel wound measures L 1.4 cm x W 0.6 cm with depth of 0.3 cm. Wound presented with continuous slough and increased serosanguineous drainage. Edges of the wound were macerated.

Protocol: Treatment was changed to apply an enzymatic debrider to the wound bed, skin barrier periwound and covered with a foam dressing daily.

Case #3:

A seventy-five year old obese patient with peripheral vascular disease and previous chronic slow healing leg ulcers, partial thickness wounds of bilateral lower legs. Weekly cleansing of all wounds, filled with hydrolyzed collagen powder*, covered with foam dressing and compression wraps.

Photo #1 (12-1-05): This patient presents with partial thickness skin loss wounds to bilateral lower legs due to atherosclerotic peripheral vascular disease and a long history of non-healing wounds. Left lower leg presents with two wounds. The proximal measures L 1.1 cm x W 0.6 cm and the distal measures L 0.4 cm x W 1.2 cm, 100% granular with large amount serosanguineous drainage. The right lower medial leg presented with a wound measuring L 1.0 cm x W 1.1 cm with large serosanguineous drainage, 50% granulation and 50% slough.

Protocol: The patient was treated by cleansing wounds then applying hydrolyzed collagen powder, foam and a four layer compression wrap. The hydrolyzed collagen powder* was applied to the wounds due to the patient’s history of slow healing and diabetes.