There have been few studies in the UK which have accurately identified the number of patients treated with this type of wound, but according to Thomas (1992) patients with these wounds prove to have significant problems not least the issue of morbidity or burden on NHS resources.

The management of this type of wound is usually considered to be palliative (Grocott 1997) with goals of care aimed at providing a realistic quality of life and symptom control. For clinicians finding dressings that have the capabilities of not only to control the exudate and odour but also to improve the quality of life is ongoing issue.

For Jason it enabled him to feel part of his family again and not feel ashamed. During the second week the wound had self-debridged and exudate management continued to improve using Eclypse®. From six surgipads (20cm x 40cm) per day the padding was reduced to one - the Eclypse®.

This final thought can only begin to sum up what it must be truly like to live with this disease... ‘Can we begin to imagine what it must feel like for a patient to see part of his or her own body rotting and to have to live with the offensive smell from it, see the reaction of visitors (including doctors and nurses) and know that it signifies a lingering death’ (Doyle 1980).

He then requested that honey be tried. Collier (1997) suggests that it is important to ensure that individual needs and wishes are addressed to promote autonomy and quality of life.

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This study is aimed at evaluating the use of Activon® Tulle (Advancis Medical); a gauze tulle with Manuka honey, as a primary dressing with an absorbent secondary pad (Eclypse® - Advancis Medical). Whilst the nursing assessment was based on Roper’s (1985) Activities of Living, this study will concentrate on the wound care aspect and the management of odour and exudate.

On examination he was found to have an excess of dry scales over his anterior chest wall, areas of erythema, multiple small lesions, grade II lymphoedema and a grade III lesion with a large area of devitalised tissue, copious exudate and odour. He was pale and cachectic but denied being anaemic, the slightest exertion caused shortness of breath and he appeared weak and tired.

The tumour and lymphoedema had caused obvious distortion and subluxation of his left shoulder causing physical problems with movement and dressing. Initially his treatments consisted of a hydrofibre, a carbon pad a silver impregnated charcoal dressing, surgipads (20cm x 40cm)x six a day, and tubifast (a haemostat was available if bleeding should occur) but it was obvious that these dressings did not have the capacity to contain or manage the wound exudate and odour. On consultation Jason denied pain completely but he was never able to tolerate any compression even crepe for his lymphoedema. He stated that the odour and exudate were to him the most distressing problems.

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References

Sincere thanks to ‘Jason’ and his family, and the district nurse teams of Downton / Whiteparish surgeries, South Wiltshire PCT and Locking Hill Surgery in Stroud. Cotswald & Vale PCT

Dressings supplied by Advancis Medical.


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