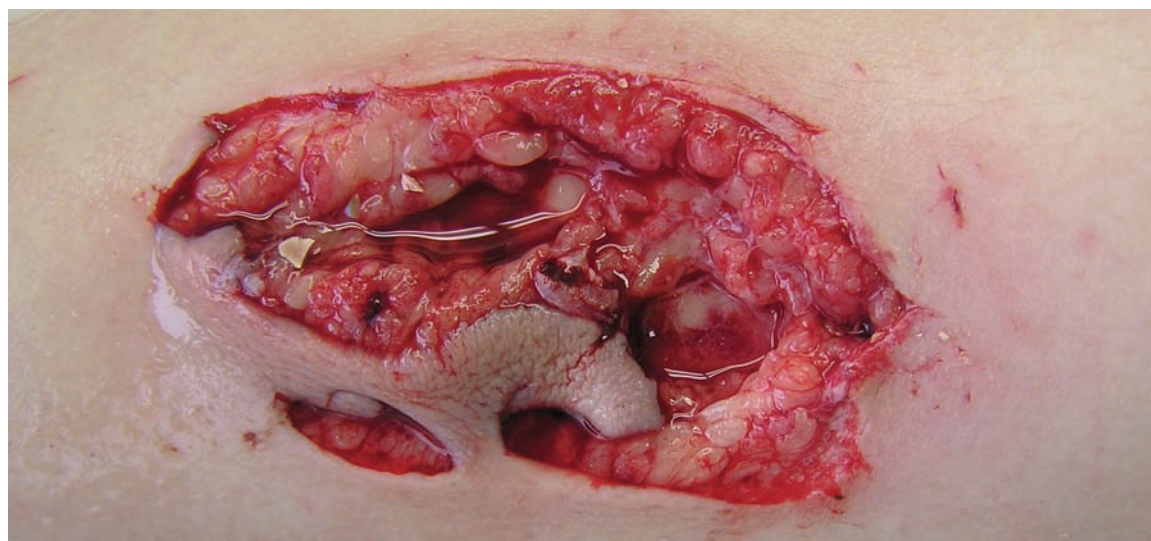


Preventing infection in superficial traumatic wounds

M.-Rebecka von Hallern



Preventing infection in superficial traumatic wounds

It's a familiar part of daily practice: treating abrasions, cuts, stab wounds, lacerations, crush injuries and bites is part of the clinical routine, which involves:

- wound cleansing and disinfection
- removal of any foreign bodies
- suturing or applying wound closure strips, as necessary
- applying primary dressings as necessary
- retaining the dressing with a gauze bandage, a tubular gauze bandage or surgical tape
- **and the treatment is finished ...**

Or is it finished?

In reality, it's not unusual for us to see these very patients returning to the Hospital Outpatient Department. On average after 24 to 36 hours, we might see the first signs of wound healing complications. The wound is painful, the wound margin is reddened and swollen. Exudation increases and the wound is sticking to the dressing.

If the patient delays seeing a doctor for even longer, after 48 to 72 hours we will see an infected wound often discharging pus, covered with slough or even with skin necrosis. At the extremities, especially the hands and fingers, movement is restricted.

If the „red streak“ of lymphangitis (also known colloquially as blood poisoning) is present, no further examination is necessary to determine the wound is infected.

And now?

From this point onwards, treating the previously simple, uncomplicated wound becomes expensive. Suture removal, wound revision, antiseptic ointment, application of an immobilizing plaster of Paris splint if required, possibly prescribing oral antibiotics. Secondary wound healing may now take a while or

in some cases, inpatient treatment for severe infections might be required.

The consequence?

As these complications occur more frequently than is generally assumed, it might be worth considering to provide suitable prophylactic antibacterial therapy immediately after the accident occurs. The most suitable approach would be a non-medicated wound dressing which does not adhere to the wound, removes painlessly and has the additional benefit of antibacterial action.

For this reason we have been using the wound dressing Cutimed® Sorbact® for almost three years in our Casualty Surgery Outpatient Department. At first only used in secondary and chronic wound treatment for pressure ulcers, venous leg ulcers, diabetic gangrene and after abscess incisions, we then decided to start using the dressings on traumatic and infectionprone wounds that had been treated surgically. This was a great success, as demonstrated in the following for the treatment of minor wounds.

Summary

When used properly, an antibacterial dressing is worth considering as a preventative treatment for superficial traumatic wounds. The secondary costs resulting from complications, especially if antibiotics have to be prescribed, are considerable.

Since using Cutimed® Sorbact® as a preventive antibacterial dressing, we have seen fewer patients with posttraumatic problems such as infections or wound healing complications. Our statistics demonstrate a decrease in the rate of wound infections associated with superficial traumatic wounds.



Abrasion wound



... after 36 hours



Stab wound (fishing hook)



Stab wound



Bite wound



Lacerated wound, 2 days old



Infected wound on the lower leg caused by bicycle spoke

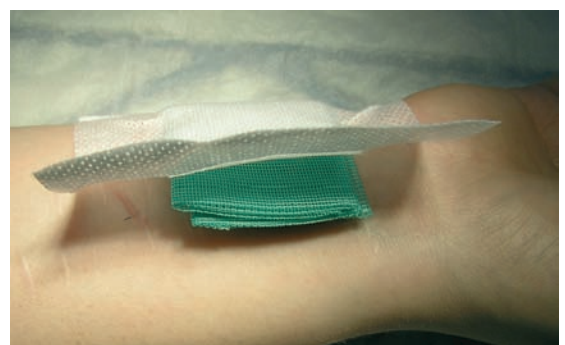


Wound infection after 48 hours

Providing a simple antibacterial dressing



Sutured cut wound on the wrist

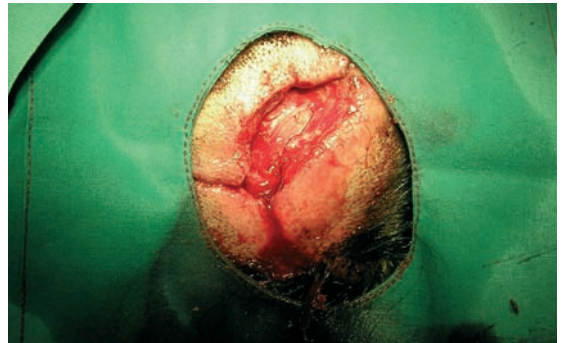


A Cutimed® Sorbact® swab is applied underneath the sterile adhesive dressing

First aid treatment of an infected lacerated head wound



Infected lacerated head wound, 72 hours old



Wound margin excision under local anesthesia



Wound margins have been adapted



Application of a Cutimed® Sorbact® swab



Fixation with an elastic bandage

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Note:

The product name Cutisorb® Sorbact® was changed to Cutimed® Sorbact® in 2008. The case reports were performed using Cutisorb® Sorbact® swabs and absorbent pads.