

Multiple Stage IV Ischemic Ulcers

Clinical Case Study

Introduction

An elderly black female was admitted to an acute care hospital from a nursing home with a large sacral ischemic ulcer which was covered by eschar. There were eschar covered areas on her right and left ischial tuberosities and right trochanter. At the time of admission, she had an elevated temperature of 40° C. Shortly after admission, a surgical consult was initiated and surgical debridement of the sacral wound was performed at bedside. At the time of debridement, a large amount of purulent drainage was found under the eschar. The patient was placed on IV antibiotics for the infection and IV fluids to correct dehydration.

Previous History

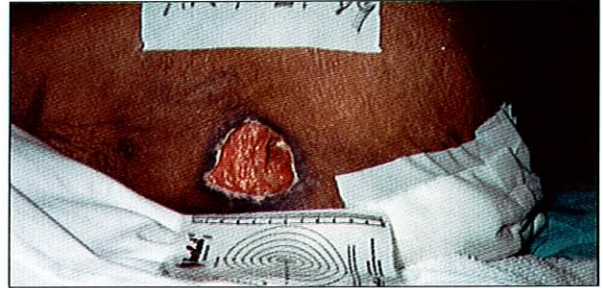
Previous to this admission the patient had bilateral above-the-knee amputations for peripheral vascular disease. She was a known diabetic regulated with insulin. A previous cerebral vascular accident had resulted in the patient being aphasic. Her only response was to painful stimuli.

Medical Management

In conjunction with IV antibiotic therapy, local wound care consisted of wound irrigation with sterile normal saline and an absorptive dressing twice daily. The patient was placed on a ROHO® DRY FLOATATION® Mattress System as a therapeutic support surface. After three days in the acute care hospital, the patient was transferred to the Skilled Nursing Facility within the institution. Because of the patient's general condition, conservative therapy consisted of appropriate IV antibiotics, tube feedings via a gastroscopy tube and local wound management. No further surgical debridement of the sacral or bilateral ischial ischemic ulcers was performed. During the 4 month hospital stay, wound management remained conservative. Complications of wound healing included positive cultures for Methicillin - resistant Staphylococcus aureus. Despite the patient's generally poor condition, wound healing was realized once the wounds were debrided of necrotic tissue. A foam dressing was applied to all sites and changed PRN after debridement completed.



Left ischial ulcer with yellow nonviable tissue.



Left ischial ulcer, 1 month later, debrided of necrotic tissue with granulating wound bed.



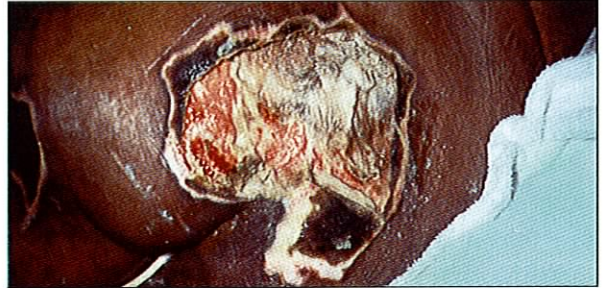
Right ischial ulcer with eschar.



Right trochanter wound communicating to right ischial ulcer. Wounds clean with granulating wound beds.



One month later, communication track between wounds closed.



Sacral wound shortly after debriding.

Discharge

Because of the patient's positive culture for Methicillin - resistant Staphylococcus aureus, continued need for skilled care and limited financial resources the placement of the patient in an extended care facility was difficult. Eventually a nursing home was found. Once transferred to the facility however, the patient expired within 24 hours of admission.

Conclusion

Despite extensive involvement of the wounds and limited financial resources for managing the patient the affected sites were significantly improved upon discharge to the nursing home. During the patient's entire acute and skilled nursing admission, the ROHO DRY FLOATATION Mattress was utilized. The patient was rotated on all turning sites to facilitate blood flow, prevent muscle contractures and hemostasis, and to redistribute ventilation and blood flow through the lungs. Most certainly, the ROHO DRY FLOATATION system proved to be an economically favorable product for this patient requiring extended stay.

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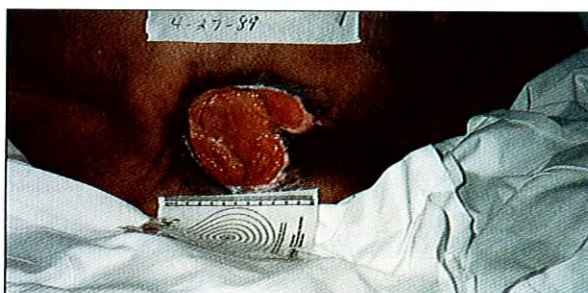
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Sacral wound with loose eschar along edges.



Six weeks later, wound contraction.



One month later.



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