An Interview with **Lincoln D'Souza**:

A Clinical Leader's Experience with

Bariatric Wound Care

Lincoln D'Souza, RN, BScN

INTERVIEWED BY Catherine Harley, Associate Editor, *Wound Care Canada*

Lincoln D'Souza, RN, BScN, is a Nurse Clinician, Surgical Out-Patient Department, McGill University Health Centre, Royal Victoria Hospital Pavillion. For over 15 years he has worked in varied settings, including the neuro ICU, plastic surgery, general surgery, transplant, vascular, urology and dialysis units. He is presently participating in the Masters in Educational Studies with a concentration in Adult Education program at Concordia University, Montreal.

Q What is your current position at the McGill University Health Centre in Montreal?

Nurse Clinician, Surgical Clinics. In this position I oversee the daily operations of the clinics, which include Plastics and Reconstructive Surgery, General Surgery, Vascular, Cardio-Thoracic, Podiatry, Bariatric, and Neurosurgery. Additionally, my practice encompasses wound care and expert consultation on patients with complex wounds.

Q How long have you been in this role?

Eight years.

Q Could you define the area of bariatric wound care for us?

Bariatrics is the field of medicine concerned with the causes, prevention, and treatment of obesity. Our particular bariatric clinic follows patients who have undergone the Isolated Gastric Bypass (IGBP), either by laparotomy or via laparoscopy approach. Some of these patients will develop incisional infections and subsequent wounds. Other patients present in one or more of the aforementioned clinics with wounds related to co-morbid factors.

Thus bariatric wound care is the care of obese people with wounds.

Q How often do you see patients with bariatric wound issues?

The exact numbers are not vigorously documented. The bariatric clinic runs two days per week, so it is possible to see patients with wounds on those days. As well patients may be referred to one of the other clinics from an outside source or from the ER.

Q How do these patients present themselves?

Anecdotally, we had a much higher incidence of post-op infections three years ago, but the nurses were able to identify that a problem existed and captured the data. Once the data were presented to the surgeon, we looked at and tried some options for reducing the incidence. The biggest breakthrough was by the surgeon, who opted to alter his surgical approach by training to perform the procedure by laparoscopy.

The original laparotomy could mean an incision from 15 cm to 30 cm. The laparoscopy route means three to five openings approximately 1.5 cm long. This greatly reduced the risk for infection and wound dehiscence. We still see many obese patients with skin fold dermatitis abrasions and/or cellulitis, excoriation from friction and shear, panniculitis, venous stasis ulcers, lymphedema, perineal and genital skin erosion from urinary and fecal deposits. Fungal and or bacterial infections may be present in the axilla and below the breasts in both females and males.

Q Could you walk us through the assessment of a patient with a bariatric wound? What are some key things clinicians should be looking for?

Many of our obese patients do not provide information that they have a "wound" because they may not be aware that one exists. It may not be possible to visualize parts

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of their body, and though they feel something, it may be difficult to identify just what they are feeling. Others may know they have a wound but over time come to accept the wound as a part of their life. The wound may become another complexity to be added to the burden of their obesity.

Assessment, therefore, often starts with patient-centered concerns. This is followed by systematically visualizing the skin folds, starting at the neck, moving down the body or in reverse fashion and lifting them out of the way to check the intactness of the area underneath.

Areas of redness, erythema, increased warmth/moistness, odour, skin breakdown and frank drainage must be identified and well documented. Assessing the incision sites for signs and symptoms of infection is the next step. It is not uncommon to have deep cavities of necrotic or liquefied fat.

Q What are the management techniques that are common to bariatric wound care?

For post-op wounds, ensuring the principles of best wound-care practice is the norm. Additionally, frequent follow-up is essential. Often the size and depth of the wound(s) are profound, so the risks for a deep compartment infection are much higher; community care and support are usually part of the plan. Keeping in mind the build of the obese patient, it is often suggested that an abdominal binder be used to maintain support and abdominal integrity.

Q Are there members of your wound-care team who play a key role with these patients? Who are they and what role do they play?

The team presently consists of a nurse co-ordinator who is the primary source for contact. There are two nutritionists who are actively involved in assessing the patients' nutritional status by interviewing and by the use of diaries. Coaching is a tried-and-true method to encourage patients to be and remain involved and motivated in their self-care. The operating MD as well as a consulting general surgeon are available during the clinics for general medical assessment and treatment as needed. The surgeon's secretary is an integral member of the team as she may be the first person the patient speaks to when things are not going well.

The patients themselves are another important resource. We have created a number of support groups and meetings where patients can meet with a moderator to discuss their concerns and experiences and to offer testimony. As well, the McGill University Health Centre has developed and maintains a bariatric Web page at www.weightlossurgery.ca for all to access.

The bariatric program has entered into an agreement with a private company that can provide personal trainers, physiatrists and even a psychologist if needed.

Q How long does it take for these patients to heal?

This is a difficult question because healing will depend on the location and cause of the wound as well as the severity of any co-morbid factors, the nutritional status and the patient's mobility status. Suffice it to say that incisional wounds may take longer than 12 weeks to heal.

Q How do you go about teaching these patients and their families?

We use frequent clinic visits as a means to follow up the progress of the patient as well as using the time to reinforce any previous teaching. We have developed a comprehensive booklet (available in either French or English) that is given to the patient at the first visit with the surgeon.

The booklet contains the name and contact information of the Bariatric Nurse Co-ordinator, as well as numerous online resources. Prior to the surgery the Nurse Co-ordinator holds a group teaching session (twice a month—once in French, once in English) where a number of patients who are awaiting the IGBP come together and are given the same information at the same time.

During this session they are free to get contact information from other attendees, thus forming their own coalitions and support system right from the beginning. They are then able to discuss with each other areas that may not be so clear, and in essence are a sounding board for each other.

Patients are invited to contact the nurse at any time; his phone number and voice mail are provided and, during the work week, he will return any calls within 24 hours.

Q How would you sum up the hurdles faced by the patients you see in the bariatric clinic?

Obese patients face numerous challenges. The excess weight not only affects their quality of life and their life expectancy, but unfortunately they must face the biases and unforgiving nature of a society that does not recognize and accept the person that lies below the fat. Mental anguish and pain are other components of the burden they must bear. Importantly, we must recognize, identify and expose these issues if we as health-care providers and members of society wish to truly help lighten the load.

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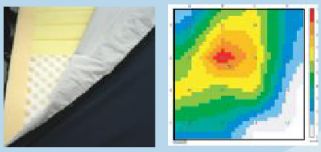

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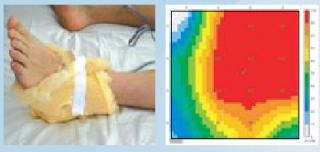

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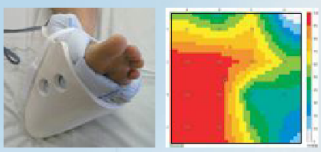

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