Wound Care Beyond Canada: A Global Perspective

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As wound-care professionals in Canada, there is no doubt that we are very busy people. Our appointment books are full months in advance; we spend our days keeping our clinics up and running; oftentimes evenings are spent catching up on paperwork or updating our knowledge, and our weekends can be written off with conferences and meetings.

We can be so taken up with trying to stay on top of things here at home that it's hard to make the time and find the energy to have a peek over the fence and see what our neighbours in other parts of the world are doing.

In a perfect world this is something we should be doing on a regular basis, so that we can learn from others, share ideas with them or even just recognize that sometimes we are all confronted with the same difficulties and challenges, no matter where we are.

The Global Perspectives stream of the Third Congress of the World Union of Wound Healing Societies was an ideal time and setting to do just that. Some of us who were there would like to share a few of the highlights of this stream with you—and give you that glimpse into our neighbours' yards.

Professional Education

One of the fundamental and most important elements of any field within health care is education.

The first speaker, Leah Shapera, talked about the Canadian experience in a hospital setting. Different methods of teaching were used that included off-unit, on-unit, policy and procedure open-book reading and video. Shapera concluded that the most effective method of teaching was off-unit and the least effective method was policy and procedure open-book reading.

In the U.S., treatment for pressure ulcers is not funded unless there is a prevention program in place. Speaker Catherine D'Amico noted that many health-care professionals disagreed among themselves regarding prevention and treatment modalities. They were frustrated with the lack of value placed on prevention programs by their institutions.

In Iran, the focus is on diabetes. Diabetes is expected to affect 75 per cent of the population by 2025, according to speaker Mahvash Salsali, who emphasized the need for diabetic education and foot care.

In summary, we see that there is still a lack of knowledge regarding chronic wound-care within health-care professions, and it was felt that chronic wound care should be integrated into the basic levels of education for all health-care disciplines.

Setting up Wound-care Clinics

José Conteras-Ruiz took us along with him on his journey toward setting up a wound-care clinic in a public hospital environment in Mexico, where resources and knowledge were limited. He took us from the earliest days when the only equipment his clinic had was a bucket, and patients had to bring their own clean water and dressings to today, where the same clinic now sees 120 patients per week, treating leg, diabetic foot and pressure ulcers.

The clinic also works with the doctors and nurses, teaching them the necessary skills of wound care and engaging them in research projects. Contreras-Ruiz emphasized that institutional support was a key element of success in this undertaking.

The take-home message here is that regardless of obstacles that present themselves, winners never quit.

Setting up Wound-care Societies

Wound-care clinics cannot function without considerable support in the form of a strong wound-care community. George W. Cherry, who has been involved in the

formation of three European wound-healing societies and is currently chairman of the Oxford International Wound Healing Federation; Michael Woodward, president of the Australian Wound Management Association (AWMA); and Evonne Fowler, who has been personally involved in the formation of the Association for the Advancement of Wound Care (AAWCC) and the Symposium on Advanced Wound Care (SAWC) gave us European, Australian and U.S. perspectives on the requirements for setting up a wound-care society.

According to these speakers the following elements are essential for setting up strong and successful wound-care communities: A need for knowledge, motivated and enthusiastic individuals with a shared objective, strong leadership, focus on good communication, problem identification and industry support.

Tools that were found to be useful in the process were community-specific journals, use of surveys to learn about the needs of community membership, career centres and Web sites. One interesting opinion expressed was that communities are made stronger by coming together, and this is how the AWMA models itself. It is a core group that provides a voice to organizations both regional and territorial, all of which maintain their autonomy.

Barriers to success were mainly time constraints and logistics—predominantly distance. All speakers made reference to the importance of support from industry. No modern community can function without material resources, and a wound-care community is no different. Willi Jung spoke about the role of industry in helping to set up a wound-care community. His opinion was that industry helps in several areas: identifying a problem and its extent, bringing the right people together, defining the goals (such as specific improved patient outcomes) and providing financial support.

Lymphedema

From speakers Christine Moffatt, Terence Ryan, Phillip Morgan and John Macdonald, we learned that our lymph system usually carries away 2 to 6 litres of fluid in a 24-hour period, and if this system is damaged in any way, high-protein edema will result. Edema is best managed with short-stretch compression and not diuretics.

The speakers further emphasized a multidisciplinary team approach, as this condition is not only taxing to patients and their families, but to their caregivers as well. Christine Moffatt suggested that we "spread the misery among the team" as our "need to heal" frustration can bring us down.

Treatment Adherence and Culture

In this series of talks, Patricia Price discussed an international survey that collected the views of over 900 patients with venous leg ulcers, arterial ulcers and ulcers of mixed etiology. Almost 50 per cent of the patients in each group reported pain most or all of the time, one third of patients in each group reported pain at dressing change most or all of the time and 40 to 45 per cent in each group reported pain at dressing change that took more than three hours to resolve.

Each group related that of six issues associated with having an ulcer, pain was the most problematic, followed by not being able to have a bath. Leg ulcer patients had the most problem with odour, while mixed ulcer patients said leakage was a major problem.[1]

Zulifiqarali G. Abbas from Dar es Salaam, Tanzania, talked about a study aimed at characterizing risk factors for foot ulcers in that country. A total of 1,451 patients were enrolled over nine years. Recorded clinical data and epidemiological data included ulcer site and area, tissue loss grade, infection grade, presence of septicemia, Wagner scale, degree of neuropathy and limb perfusion. Recorded outcomes included septicemia, healing and mortality.

Study results indicated that parameters such as tissue-loss grading of ulcers, limb perfusion and ulcer size were significant predictors of healing, septicemia and mortality. Wagner scale and ulcer size, however, did not correlate with outcomes.[2]

Paul Philcox from Australia looked at the impact of chronic wounds on people who do not actually suffer from them. His team looked at 300 unsolicited comments returned along with questionnaires originally sent out into the community to determine the prevalence of chronic wounds in a community setting. They found that people wanted to share their experiences, and supported valuable research. They

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also related fears about wound development/recurrence, the difficulties that arose when caring for someone with an ulcer and lack of concern by health professionals as people got older.[3]

The take-home messages are that ulcers affect people other than the direct sufferers and that these people are anxious to share experiences, anxieties and information and, finally, that health professionals need to listen more.

Richard Salcido spoke about the importance of smoking cessation and gave us a long list of smoking-related health complications, especially wound-related. For example, smoking can cause delayed healing in post-operative patients, wounds can rupture and incisional hernias can develop. Incidence of pressure ulcers is higher in patients with spinal cord injury who smoke. Smoking interferes with fibroblast migration and with various other cell types involved in wound healing. It increases blood viscosity and vasoconstriction. It lowers levels of oxygen circulating in the blood. If smokers needed any more motivation to quit, these facts surely provide it!

Making a Difference

It was noted that skin tears are the third most common wound of the elderly after trauma and pressure ulcers. Australia has developed the skin tear audit research (STAR) skin tear classification system that provides another tool to help in a comprehensive patient assessment.

Pain is an important factor to be considered when assessing a patient. The pain a person with diabetes experiences is often underestimated and may not always relate to the gravity of diabetes or its complications. Perception of pain may be related to past experiences that have been either positive or negative. When considering pain, clinicians should look at the dynamic nature of the pain, the interpersonal and social context of the pain, therapeutic relations and the possibility of the use of psychotherapy for help in dealing with the pain.

Pain, as we know, can be most bothersome at dressing change. Hilde Fagervik-Morton suggested that we need to identify and incorporate patient concerns into goals of treatment. Patients want us to, "Listen to me when assessing my pain," and encourage the discussion of the use and change of analgesia with them on a regular basis.

In the U.S., a pressure ulcer collaborative was established across care settings. The goal of the initiative was to reduce the incidence of pressure ulcers by 25 per cent. With improved communication and education of both staff and patients the incidence of pressure ulcers was reduced by 70 per cent in two years. This initiative reinforces and supports the CAWC Pressure Ulcer Awareness and Prevention program.

Cost versus Cost-effectiveness

The difference between cost and cost-effectiveness was defined by Patricia Price. Cost effectiveness is defined as not necessarily cutting costs (e.g., "Why aren't we using dressing A when it is 50 per cent less expensive than dressing B?"), but being able to look at the big picture and demonstrate the most effective use of available resources (e.g., "Patients who use dressing B have been shown to develop 30 per cent fewer infections and their time to healing is 25 per cent faster than with dressing A, thereby saving us money in the long run").

A study from Germany on patients with venous leg ulcers presented by Matthias Augustin showed that average costs (direct and indirect) per patient per year range from €9,900 to €10,800[4] (approximately $15,900 to $17,400 CDN). This is without doubt evidence to motivate us to be conscious of how we are spending our money on wound care, no matter where we are in the world.

Geoff Sussman presented an Australian study that evaluated the cost-effectiveness of a multidisciplinary wound-care team compared with usual care in a nursing home setting. It was shown that more wounds healed in the treatment arm than in the usual care arm and there was faster healing and significantly less pain in the intervention group. The mean treatment cost was $616 AUD for the intervention group and $978 AUD for the control group[5] (approximately $603 and $956 CDN, respectively).

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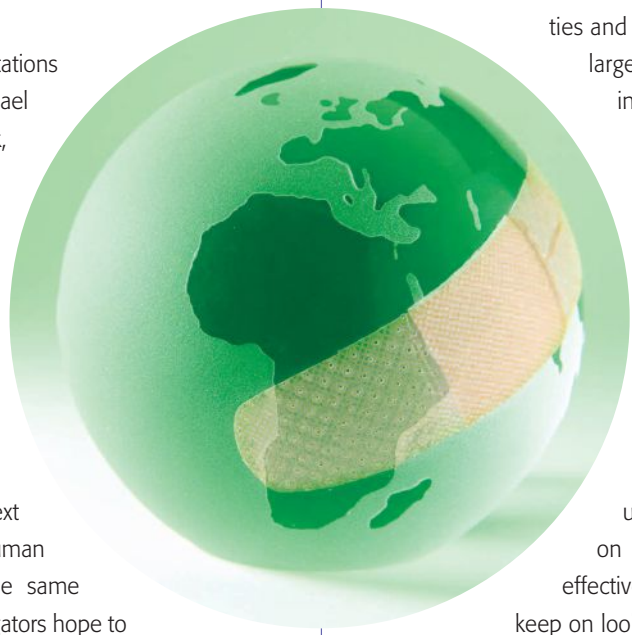
When asked what the next step in the various countries should be, presenters responded that practitioners need to be educated in cost-effectiveness. It was felt that more high-quality research needs to be done to demonstrate cost-effectiveness of products and interventions, and that bureaucracy needs to learn to move its focus away from cutting costs and look more toward the bigger picture—i.e., cost-effectiveness.

Special Consideration for Leg and Foot Ulcers

This series of presentations was opened by Michael Golinko from New York, who, using a mouse model, demonstrated that while age alone or diabetes alone does not necessarily impair wound healing, both age and diabetes combined do impede the process. The next step is to look at a human model and see if the same holds true. The investigators hope to help clinicians realize that just because a patient is old or diabetic does not mean that their wounds cannot heal.



Magnus Agren from Denmark presented some of his work looking at wound fluid as a gauge for healing. He compared wound fluid from acute wounds with that of chronic venous leg ulcers with duration of greater than three months and recorded the protein alterations that were unique to the chronic wounds. He found that fibronectin, Von Willebrand factor and C-reactive protein levels were significantly increased in the chronic wound fluid.

Marco Romanelli provided us with the results of a randomized controlled clinical trial carried out in Italy. Amelogenin extracellular matrix therapy, which provides a temporary matrix for cell growth in the wound bed in combination with compression therapy was compared to compression alone. His group found significant reductions in ulcer size and reduction in both pain and exudate levels. Follow-up at 12 weeks post-treatment showed that the beneficial effects were maintained.

Conclusion

From this very brief overview it can be seen that when we look out there, it's a little like looking into a mirror—we are not all that different from each other. We all have our difficulties and challenges, some quite large and initially intimidating, some less so. We all have areas where we excel and are leaders and teachers. Conversely, we all have our weak areas where we need to let someone else show us the way forward.

We can see that ultimately we depend on each other to function effectively, so it is vital that we keep on looking out there and keep on letting others look at what we are doing because that is how we learn, teach and progress as a single global community.

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