

# WoundPedia:

## Resources in Evidence-Based Practice



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**T**he subject of evidence-based practice is not new in the area of either health or wound care, but in the latter case it has a long way to go to help caregivers in everyday practice.

Implementing best practices—those supported by evidence—is a growing requirement of global health-care systems and is an ongoing challenge for most of us in our daily lives. The World Union of Wound Healing Societies (WUWHS) continues to develop and disseminate best practice documentation through its collaboration with its industry partners. The Third Congress of the World Union of Wound Healing Societies held in Toronto in June 2008 saw the launch of many important tools to aid in the further development of this important approach to care.

All of these tools have resulted from global approaches to a common problem. Fitting with the theme of the 2008 WUWHS Congress the resulting products come as one common voice.

Congress 2008 delivered a strong global message of “Evidence, Evidence, Evidence,” but most importantly focused on its implementation into practice. And here lies a challenge: don’t just absorb the publically available knowledge, consider becoming part of its development. If you are involved in any way in clinical research or trials, publish your work to ensure that it can be considered as part of the emerging evidence for our practice.

The 2008 WUWHS Congress saw the launch of an important Web-based evidence tool—*WoundPedia*—that will help caregivers access, understand and implement the evidence base available for wound care. This new and exciting WUWHS product is freely available to all caregivers globally and is the beginning of a centralized initiative to facilitate the global development of more appropriate evidence-based medicine for wound care.



### WoundPedia

The focus of *WoundPedia* is not to labour old ground regarding evidence definition and process, but rather to provide the information and tools necessary to aid its integration into practice. *WoundPedia* will also provide an opportunity to become involved in the ongoing process of evidence gathering, appraisal and presentation.

*WoundPedia* is a Web-based ([www.woundpedia.com](http://www.woundpedia.com)) free-content encyclopedia-type resource that contains collated evidence to support the clinical arena of wound care. *WoundPedia's* summaries provide easy links to guide the user to related pages.

*WoundPedia* is written collaboratively by experts worldwide. Created in early 2007, *WoundPedia* is expected to grow into one of the largest wound-care-evidence reference Web sites. Currently more than 50 active contributors are working on nine summaries, with topics organized by etiology or theme.

Unlike a paper reference source, *WoundPedia* is continually updated, with the creation or updating of summaries on topical events occurring within days or weeks, rather than the years usually required for printed sources.

The summaries are never complete; they are always

in transition, as the content is continually edited and improved over time. This results in an upward trend of quality, and a growing consensus of fair and balanced representation of information.

A *WoundPedia* summary contains comprehensive, verifiable, evidence-informed knowledge. The summaries reach this standard over time, and even in the short time of the existence of *WoundPedia*, many already have. The summaries are generated through teams that include many of the world's experts in each clinical area. This is done through *WoundPedia* Generator, a private content management Web site that allows this consensus process to happen. Unlike *Wikipedia*, the popular online encyclopedia, our content is peer reviewed.

The statements and recommendations are based on the best available evidence, expert knowledge and in some cases patient preferences.



Visitors do not need specialized qualifications to view the materials; people of all expertise levels and cultural and social backgrounds can find *WoundPedia* articles useful, including patients and their families.

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## Diabetic Foot Ulcers *continued from page 14*

There are three main factors that contribute for elevated foot pressure resulting in ulceration:

- Intrinsic: Genetic/Structural
- Extrinsic: Shoes/Traumatic accident/Surger
- Behavioral: Poor choices of footwear/Walking pattern

There is ongoing research into the impact that shear forces may have on ulcerations of the diabetic foot. It has been found through pressure mapping that the locations of "peak shear pressure" are different from the locations of general "peak pressure" of the foot. More research is planned in this area.

The takeaway message is to look at structure, function and footwear to be able to treat the diabetic foot appropriately.

### Offloading

It was stimulating to hear that the term *offloading*, is being changed to *tissue protection*, as offloading is limited to devices but fails to factor patient activity and lifestyle. The change in term should aide in patient understanding of their condition.

On the issue of devices, it was stressed that no open ulcer should be treated with shoes and orthotics. The total contact cast (TCC) and the instant total contact cast (ITCC) still offer the best healing rates in forefoot diabetic ulcers. There was no difference in peak pressure between TCC and ITCC. It was pointed out that the ITCC had advantages over the TCC as it is easier to apply, less expensive and can be used in infected wounds.

Some presenters found through their work in their clinical practice that the majority of patients with diabetes don't require custom-

made shoes unless they have a severe deformity like chronic Charcot. There are presently on the market multiple extra-depth shoes that can be modified.

It was highlighted that even though the evidence was poor on the efficacy of footwear in ulcer prevention, it was still an important part of managing the diabetic foot and more research is needed in this area.

After healing of the diabetic foot ulcer, there should be a transition period of three or four weeks before returning to regular footwear, otherwise the foot may reulcerate.

### Diabetic Foot Surgeries

Robert Frykberg presented his surgery classification system, which was validated in 2006.

### Amputations

Neuropathy is one of the leading factors (equivalent to ischemia) contributing to increased rates of lower limb amputations.

Digital amputation, and specifically hallux amputation, often results in biomechanical alteration, digital contractures, ulceration and fractures. Keeping all toes is not always in the best interest of the patient's long-term goals related to rehabilitation, footwear, mechanical stress when walking and quality of life.

The most common foot amputations performed (in order, from distal to proximal) are transmetatarsal, Lisfranc and Chopart. Sometimes, shorter is better!

### Prevention

Lawrence Lavery commented that most of the diabetic foot-care recommendations

have execution problems as a result of self-care barriers such as limited range of motion, obesity and visual impairments.

It was also stated that optimal foot care alone is 25 to 45 per cent effective at decreasing the rate of diabetic amputations. Caregivers who are educated in foot care can catch problems early (61 per cent). Males were shown to be less likely to attend foot-care clinics. Men experience a higher rate of foot infections and amputations when compared with women due to their beliefs and lack of access to care.

We were reminded by the diabetes educators, that for us to achieve amputation prevention, we need behavioral change. The only way this can be achieved is to consider the patient, clinician and environment. The area many of the presenters found challenging and that is often forgotten is the environment. This was a repetitive theme in the area of adherence to medication, devices and self care.

The future seems positive in the area of the diabetic foot ulcers through ongoing research. With emerging technologies, the cornerstone to managing the diabetic foot seems to remain a thorough assessment of the VIP (vascular, infection and pressure) and correction of these factors, a patient-centred approach, use of a multidisciplinary team and patient education. We were also reminded throughout the diabetic stream that our key goal as clinicians is to improve quality of life, limb salvage and to prevent recurrence of ulcers. To achieve this, early presentation, swift diagnosis and timely treatment are needed. ☺

## Research *continued from page 50*

### G. Gethin

Manuka honey versus hydrogel to deslough venous ulcers: A randomized controlled trial.

In this study the role of honey was compared with hydrogel in persons with VLU. Overall, honey may be more efficacious than hydrogel in the initial treatment of sloughy venous ulcers; it demonstrated statistical superiority over hydrogel for

reduction of slough at four weeks and for healing outcomes after 12 weeks.

### Katrina Bruzdanski

Evaluation of efficacy: Canadian honey against wound infecting bacteria.

In a laboratory study of various Canadian honeys' action against bacteria in culture, four strains of MRSA, three of VRE and

*E. coli* were investigated. The most susceptible to honey's effects were two strains of MRSA, and the least susceptible was *E. coli*. The most effective honeys were monofloral (buckwheat and blueberry). Canadian honey is not as active as Manuka honey against the studied strains of bacteria but still had significant bacteriostatic efficacy. ☺

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