Wound Sleuth

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Addressing the Wound Healing Needs of a Person Who Injects Drugs

Mr. B, a 55-year-old male patient, arrived at the community-based methadone clinic with a wound on his upper left buttock.

He is a person who injects drugs (PWID), and after his last injection was unconscious for 16 hours. When he awoke his left buttock was red. He is currently enrolled in a methadone maintenance program for opioid dependency but is struggling with maintaining sobriety. His co-morbid conditions include spinal stenosis and malnourishment. He smokes daily. He has no known allergies and does not abuse alcohol.

The ulcer was located on his left buttock 5 cm below the iliac crest. It was 7.5 cm wide, 7.5 cm long and 5 cm deep, with ragged, necrotic edges. The wound bed was covered with necrotic tissue. It was draining with an offensive discharge.

Q What is the cause of this wound?

A Because of this patient's history and current status, the following were considered: pressure while unconscious, overall poor nutritional status (failure to thrive) related to food access and choice, chronic opioid abuse, underlying osteomyelitis, lack of exercise and mobility, and vasculopathy.

Q How would you determine a diagnosis?

A A complete history and assessment of Mr. B's lifestyle leads to a likely diagnosis of a single, extended period of pressure on the buttock.

Q What is the treatment?

A Interventions need to be two-fold:

One: Address the original cause of the wound: pressure during a long unconscious episode. What is the risk that something similar might happen in the future? If the risk is moderate to high, develop and implement a prevention strategy with Mr. B.

Two: Treat the wound. As the wound had necrotic tissue and was infected, the initial treatment included debridement, antimicrobial wound dressings and systemic antibiotics based on the results of a culture sample and sensitivity. Antibiotic management for osteomyelitis continued after the initial treatment.

While we were able to address Mr. B's immediate wound concerns at the methadone clinic, we recognized he needed further investigation and specialized treatment, so we referred him to a nearby multidisciplinary wound clinic for additional care.

Outcomes

After referral to the wound clinic, where they initiated negative pressure therapy (see Figure 1) as part of the care plan, the wound drainage, foul odour and necrotic tissue resolved and the wound became smaller and shallower, with good granulation tissue in the base (see Figure 2) over the course of eight weeks. It is important to note that negative pressure wound therapy is not generally considered a first-line treatment for patients living with a pressure

Q What could inhibit healing in this patient?

A In this case, clinicians should ask themselves the following:

- Could healing be impaired by a negative protein balance?
- Could the maladaptive lifestyle behaviour influence the healing process? For example, where does the patient sleep and on what? Are there any sleeping positions he maintains for long periods of time?
- Could drug use influence the wound-healing trajectory?

injury. However, in this case, after the cause was addressed and a comprehensive risk assessment done, the wound clinic prescribed NPWT for the patient.

Mr. B was encouraged to continue to attend the methadone clinic to reduce his risks for recurrence and additional adverse events due to his drug use.

Figure 1: Negative pressure therapy applied to the wound

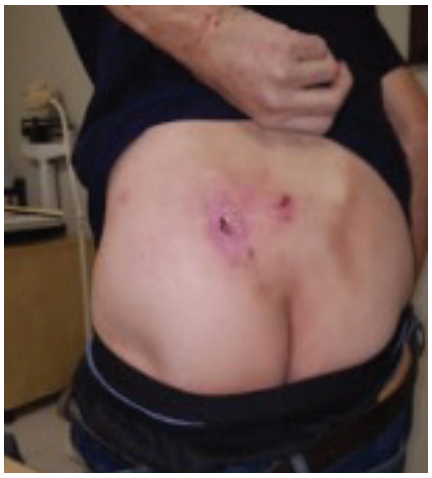

Figure 2: The base of the wound showing healthy granulation tissue, a pink colour and reduced size and depth following negative pressure therapy

Takeaway

All patients deserve timely wound interventions—including appropriate referrals—to prevent complications and recurrence.

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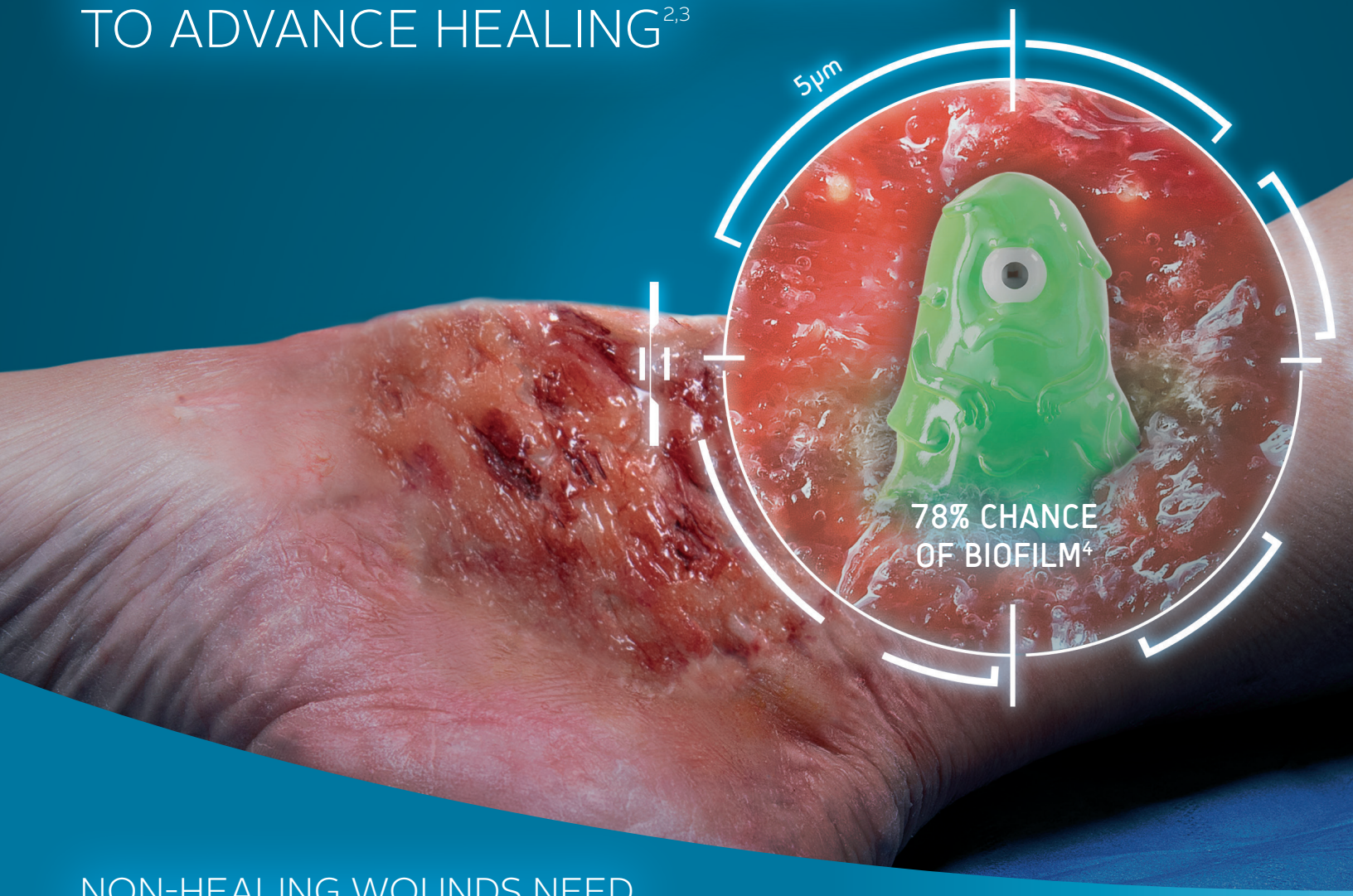

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1. Bowler PG, et al. Parsons, Wound Medicine 14 (2016) 6–11. 2. Metcalf DG et al. J. Wound Care 2016; Vol25, No3. 3. Metcalf DG, et al. Int Wound J 2017; 14: 203-213. 4. Malone M et al. 2017. JWC; 20-25.

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