Pearls for Wound Care in a Primary Care Setting

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Disclosures

- None for this program
Where do you work at?
- Office only
- Office and hospital
- Office and some type of long term care facility
- Hospital ER/Urgent care

Basic obstacles to acute/chronic wound closure:
- Vascular Supply
- Adequate Debridement
- Infection Control
- Offloading/pressure reduction
- Edema/Exudate control
- Moist Wound Healing
- Diabetic control/nutrition
- Pt understanding of their condition/(don’t always blame compliance)
- IF ALL of the above are not addressed – THEN NOTHING WILL WORK
Wound Types

- Arterial/Ischemic
- Venous
- Diabetic - may have many components
- Pressure
- Traumatic
- Other (vasculitic, calciphylaxis, malignant)

If a wound is not healing or has been there for and no etiology or improvement within 6-8 weeks then >>>>>> BIOPSY IT!!!!!!
Right foot erythema, swollen calf and ankle and painful in foot what test would you do?

Foot is actually cool to touch - and elevation all redness goes away does this change what you would do?
This is critical limb Ischemia!!! Rule of Artery is supreme! Always check arteries 1st!!

<table>
<thead>
<tr>
<th></th>
<th>Diabetic</th>
<th>Nondiabetic</th>
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<tbody>
<tr>
<td>Clinical</td>
<td>More common</td>
<td>Less common</td>
</tr>
<tr>
<td></td>
<td>Younger patient</td>
<td>Older patient</td>
</tr>
<tr>
<td>Occlusion</td>
<td>More rapid</td>
<td>Less rapid</td>
</tr>
<tr>
<td>Male/female ratio</td>
<td>2:1</td>
<td>30:1</td>
</tr>
<tr>
<td>Vessels adjacent to occlusion</td>
<td>Involved</td>
<td>Not involved</td>
</tr>
<tr>
<td>Collateral vessels</td>
<td>Involved</td>
<td>Usually normal</td>
</tr>
<tr>
<td>Lower extremities</td>
<td>Both</td>
<td>Unilateral</td>
</tr>
<tr>
<td>Vessels involved</td>
<td>Tibial artery</td>
<td>Aortic artery</td>
</tr>
<tr>
<td></td>
<td>Peroneal artery</td>
<td>Iliac artery</td>
</tr>
<tr>
<td></td>
<td>Small vessels</td>
<td>Femoral artery</td>
</tr>
<tr>
<td></td>
<td>Arterioles</td>
<td></td>
</tr>
<tr>
<td>Gangrene</td>
<td>Patchy areas of foot and toes</td>
<td>Extensive</td>
</tr>
<tr>
<td>In-hospital mortality with amputation</td>
<td>Approximately 3%</td>
<td>Significantly less</td>
</tr>
</tbody>
</table>
Screening for PAD

- Palpable pulse and Visual Inspection
- Ankle/Brachial Index
- Toe systolic pressure and index (if ABI elevated)
- Transcutaneous Oximetry
- Arterial Ultrasound
- Angiogram
Office Measurement of the Ankle–Brachial Index (ABI)

Right arm pressure
Pressure: PT, DP

Left arm pressure
Pressure: PT, DP

Adapted from the PARTNERS Program.
Critical Limb Ischemia (CLI):
Allie et al, Eurointerventions, May 2005  “Costs of CLI”

- “**Shockingly**” primary amputations (PA) are **“still the most common CLI treatment”**
- In 2000-2001, **67%** of USA CLI pts had **primary amputation** as initial treatment**
- “**More shockingly**” **50%** PA are performed **without angiography or a simple ABI!!**

** Strategic Health Resources commissioned by the Spectranetics Corp.**
The “Pathway to Amputation”

67% had PA as first CLI treatment (N=417)
26% had cardiology consultation
21% had vascular surgery consultation
Only 35% had ABI before PA!
Only 16% had angiography before PA!

“<50% had any vascular evaluation”

PTA as the First-choice Revascularization in Diabetics with CLI: Prospective Study of 993 patients between 1999 and 2003

Faglia, E., Dalla Paola, L. Graziani Eur J Vasc Endovasc Surg 29, 620-627 June 2005

Non Surgical Interventions:

1. PTA was safe and feasible
2. Low complication rates (3.4%)
3. High Success rates (97.8%)
4. Low major amputation rates (1.7%)
5. 5-Year clinical primary patency rates (88%)
6. Stressed a “MULTIDICIPLINARY” approach
7. Again > 90% long term LIMB SALVAGE
The effectiveness of PTA for the treatment of CLI: 10-year experience
Ahn, Samuel S. et. al. (J. Vasc. Surg. 2005; 41: 423-433)

Conclusion:
- 0.9% perioperative mortality
- Overall technical success = 96.4% (N = 139)
- Overall clinical success = 92.8% (mean=14.7 mo)
- Overall 5 year primary patency = 31.5%
- Overall 5 year secondary patency = 79.6%
- 5 year limb salvage = 89.1%

"Contemporary" -- 2005!!
**Critical Limb Ischemia (CLI):**

- Rutherford Classification 4, 5, 6…
- ~220-240,000 amputations/yr USA/Europe
- ~4-30% 30-day perioperative mortality!
- ~8-37% 30-day perioperative morbidity!
- $10 - 20 Billion / Yr. US costs of CLI !!

“> 20,000 amputations/month !”
Combination Therapy
(Chemical Thrombolysis & Mechanical Thrombectomy)

- Goals:
  A. Reduce mortality (shock, sudden death)
  B. Treat the “GREAT TOE” like the “LAD”
  C. Decrease embolic risk
  D. Improve clinical outcomes

Treat “ALL” like “ACS”

Critical Limb Ischemia (CLI):

- < 50% of all amputees achieve mobility
- < 50% of amputees are alive at 3-4 years…
- 1/4 all Diabetics will face CLI (20 Million)
- Multiple reports of >85-90% 12-24 mo. Limb Salvage rates- Endovascular Therapy & Surgical Bypass …
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Critical Limb Ischemia (CLI):

- Within 18-mo of successful limb salvage …
  1/3 require “re-salvage” reintervention
  1/3 require contralateral CLI intervention
  “Bilateral Disease”
- Within 18-mo of unilateral limb loss …
  1/3 will lose the contralateral limb!!
Adequate Debridement/Infection control

- In general resect to healthy margins
- How do you know how much to debride?
  - Usually depends on Imaging - so Get IT Done!
  - Plain films, MRI, Bone scans, WBC bone Scans, CT + bone scan if can't have MRI
- Cultures and Diagnosis of Infection – that's you – not just a culture
- In general <2 weeks Staph/Strep unless necrotic tissue present to begin with then widen DDX to gm neg and anaerobes

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Offloading

- Every step taken on a DFU delays the healing by THREE DAYS!

- Pressure ulcers in para and quadriplegics - wheelchair cushion what type do they have? Gel or Roho or custom fitted and how long are they up a day?

Review - How would you Manage this patient
Pressure map of a seated patient showing high pressures (orange areas) over the ischial tuberosities.

Diagram showing areas of the body:
- Toes
- Heel
- Buttocks
- Back of the head
- Shoulder
- Nacram
- Base of spine

Stages of Pressure Sores:
1. The area is red and may be hard to walk on; no tissue loss.
2. The area is red and hard; may be painful; no tissue loss.
3. The area is red, hard, and painful; tissue loss.
4. The area is red, hard, and painful; tissue loss and bone exposed.
Principal for possible Flap

- Six principals of wound care
- Nutrition PO/Peg/IV
- Does he need a Colostomy
- Foley vs Supra pubic
- How long in bed after a flap? Depends – usually 4 weeks minimum
- Wheelchair cushion pressure mapping
- Time up/ teaching offloading
- Psychologocial Support for Osteomy/Home Health Prevention on future ones
- DVT prophylaxis
- Excellent Medical Care – DM control, hydration, prevention
- Rehab potential
- Orders for NH etc.

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- CHF Left and/or Right
- Liver disease
- Renal Failure
- Lymphedema
- Lipoedema
- Hypothyroidism
- Venous Insufficiency

Switching Gears to Venous
Chronic Venous Insufficiency
How Important is it???

- Most common cause of ulceration of the lower extremity 9 more times common then diabetic ulcer of the foot.
What do you tell your patients about this? – by the way this patient has a 30% risk for Ulceration.
91 years old
Chronic Venous Insufficiency

- Afflicts more than 7 million individuals in the United States alone
- Worldwide prevalence of ulceration – 1 to 1.3%
- Leg ulcers due to venous insufficiency are 9 times more common than diabetic ulceration

Chronic Venous Leg Ulceration and Disease Impact

- 80 – 90% of leg ulcer cases in the US are due to Venous Insufficiency
- 68% of patients experience an impaired quality of life, pain, social isolation, and negative self image.
- 40 – 50% are chronically open wounds (for various reasons)
- Two million work days lost annually
- Physical impairment due to decreased mobility and loss of productivity
Venous Insufficiency - Diagnostic Studies

- **ABI - Ankle Brachial Index**
  - Pressure at the ankle by doppler divided by the higher of the systolic of the upper extremities
  - Normal 1.0 – 1.2

- **US of the Lower Extremities to rule out chronic DVT** (rarely needed unless history suggests - unilateral swelling more common)

- **Venous Reflux Exam**

- **Remember patients may have other conditions exacerbating their venous insufficiency**
Venous Valvular Function

- Valve leaflets allow unidirectional flow, upward or inward
- Dilation of vein wall prevents opposition of valve leaflets, resulting in reflux
- Valvular fibrosis, destruction, or agenesis results in reflux

Figure 3.5. An abnormal waveform for the Venous Reflux Test.
Doppler exam: Normal flow

Illustration by Linda S. Nye

Doppler: Reflux

Illustration by Linda S. Nye
**REFLUX:** its contribution to varicose veins

Illustration by Linda S. Nye

**Pathophysiology:** 2 components

**REFLUX**
- Dilatation of vein wall leads to valve insufficiency
- Monocytes may destroy vein valves
- Retrograde flow results in distal venous hypertension

**OBSTRUCTION**
- Thrombosis and subsequent fibrosis obstruct venous outflow
- Damage to vein valves may also cause reflux
- Both contribute to venous hypertension

The presence of both is far worse than either one alone
- CHF Left and/or Right
- Liver disease
- Renal Failure
- Lymphedema
- Lipoedema
- Hypothyroidism
- Venous Insufficiency

Compression Therapy:
- Provides a gradient of pressure, highest at the ankle, decreasing as it moves up the leg
- Reduces reflux of blood
- Improves venous outflow
- Increases velocity of blood flow to reduce the risk of blood clots

Photo courtesy of Juzo
Elastic compression stockings

- Must be graduated
- Calf high generally sufficient
- Replace q 6 months to assure proper pressure
- Available in a variety of strengths, styles, colors, and fabrics

Graduated compression is not the same as T.E.D. hose

- T.E.D.s are meant for non-ambulatory, supine patients
- T.E.D.s are indicated to decrease the incidence of thrombosis
- T.E.D.s do not provide sufficient pressure for ambulatory patients
Compression Strength | Indications
--- | ---
8-15mm | Leg fatigue, mild swelling, stylish
15-20mm | Mild aching, swelling, stylish
20-30mm | Aching, pain, swelling, mild varicose veins
30-40mm | Aching, pain, swelling, varicose veins, post-ulcer
40-50, 50-60mm | Recurrent ulceration, lymphedema

* Requires a prescription

Gradient compression hose

- At least Calf high 20-30mmhg
  - Thigh high or panty hose may be more comfortable depending on the situation
  - Open or closed toe depending on concurrent condition such as diabetes, neuropathy or concurrent arterial disease.
- The clock starts ticking when they began their compression so if you document it I can use that date for their insurance approval.

Where can they get them?
- DME store - LKM, Freeland Brown, Fidelity Lymphedema, can purchase over the counter (typically sized by the calf and thigh circumference and outseam)
- Yes some fit better than others but if symptoms helped and continue despite their stockings and reflux found - good chance they will respond to treatment.
Venous Ulceration

Impending ulceration
Lipodermatosclerosis (C4a)
Venous ulceration (C6)
Skin changes suggestive of chronic venous insufficiency

- Corona Phlebectatica (C1)
- Pigmentation (C4a)
- Atrophie blanche (C4b)
- Healed ulcer (C5)

Treatment

- #1 Education
- #2 Treat the Underlying Cause i.e., (ambulatory Venous Hypertension due to Reflux) with compression and Ablation if skin changes or history of ulceration
- #3 Prevention of progression
  - #4 Treat Ulceration promptly
  - #5 Prevent Reoccurrence
    - 70 – 90% of patients with venous Insufficiency and healed ulceration will reoccur if non-compliant with compression
    - REFER TO PHLEBOLOGIST if ablation or US for reflux not done
    - With compression ulceration can still occur 30% of the time, but symptoms and ulcerations usually resolve quickly
Diabetes - Statistics

- 1994 67,000 people with diabetes underwent one or more lower-extremity amputations

- Diabetes is the leading cause of amputations of the lower limbs

- Up to 20% have contralateral limb amputation within 1 year

- 28-50% have contralateral limb amputation within 5 years.
Arterial Disease

- 20-30% of Diabetic Ulcers are caused by multisegmental "large artery" disease
- Microvascular complications occur as well but "large artery" disease is most associated with foot ulcers when present.
- Ankle-brachial index - if abnormal, (less than 0.9 or greater than 1.3) then needs further evaluation.
- Quit Smoking!!!!!!!
- Remember 1st part of lecture !!!!
Currently only 50-60 percent of patients with diabetes have semi-annual foot exam

Ethnic groups other than white had at least a 50% higher incidence of amputations

Only 50% of diabetics inspect their feet daily and 22% never check their feet
Characteristics of Diabetic Foot Ulcers

- Round, punched-out lesion with elevated rim
- Periwound hyper-keratosis and anhydrosis
- Eschar and necrotic debris in ulcer base uncommon
- Low to moderate drainage, unless infected
- Located on plantar aspects of foot

Neuropathy

- Motor - Leads to altered gait
- Sensory - No awareness of Trauma
  - self injury to poorly fitting shoes (to tight in most cases.
  - Cutting toenails improperly
- Autonomic - Decreased perspiration - dry cracked skin/ Infection
Prevention

- DCCT trial: keeping diabetes under control, correlated with reduced risk of onset and progression of retinopathy, nephropathy, and neuropathy caused by diabetes
- 50% of amputations may be prevented through simple effective foot care practices
Where are most ulcers are located?

Assessment of Patients With Diabetic Ulcers

- Patient History
- Glucose Control
- Vascular Status
- Ulcer status and duration
- Patient understanding
- Footwear
- Physical Exam
- Nutritional status
- Neurological status
- Treatment modality review
- Patient’s support network
Risk Factors for Diabetic Foot Ulcers

- Duration/Control of Diabetes
- Neuropathy
- PVD
- Structural Foot abnormalities
- Poorly fitting footwear
- Impaired vision
- Previous ulcerations
- Inadequate foot hygiene
- Non-compliance/denial

Most common cause of diabetic foot ulcers is:

- Diabetic Neuropathy
  - Although 30-40% of these patients will have coexistent peripheral vascular disease
Screening for Neuropathy

- Loss of protective sensation 5.07gr Semms-Wientsein probe
- Cocked up toes
- Fallen arches
- Callous formation and pre-ulcerative lesions
- Dry cracked skin

Semmes-Weinstein monofilaments
Don’t forget the shoes!

- Medicare covers custom molded shoes and inserts for patients if:
- Loss of protective sensation
- Previous ulceration
- Previous amputation
- Current condition/ulceration in need of healing shoe/sandal
- RX should read: “Eval and Fit for custom inserts and custom shoes if needed”
Recognizing Trouble

- Check feet at each visit
- 80% of ulcerations are preceded by callus
- How do you treat calluses?
- Don’t know what’s under them if you don’t look
- Look at web spaces and treat tinea aggressively
- Often callous will have a tissue plane of hematoma - you know you did the right thing if you find this
## University of Texas - Diabetic Wound Classification System

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>Clean</td>
<td>Through dermis/no tendon</td>
<td>Tendon or capsule exposed</td>
<td>Bone or Joint exposed</td>
</tr>
<tr>
<td></td>
<td>5% amp</td>
<td>0% amp</td>
<td>5% amp</td>
<td>0% amp</td>
</tr>
<tr>
<td></td>
<td>*26%</td>
<td>*0%</td>
<td>*20.6%</td>
<td></td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Non-Ischemic/Infected</td>
<td>12.5% amp</td>
<td>25% amp</td>
<td>52% amp</td>
</tr>
<tr>
<td></td>
<td>*4.2%</td>
<td>*13%</td>
<td>*25%</td>
<td>*52%</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Non-Infarct/Ischemic</td>
<td>25% amp</td>
<td>25% amp</td>
<td>100% amp</td>
</tr>
<tr>
<td></td>
<td>*2.2%</td>
<td>*7.8%</td>
<td>*1.1%</td>
<td>*0.8%</td>
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<tr>
<td><strong>D</strong></td>
<td>Infarct plus Ischemia</td>
<td>50% amp</td>
<td>100% amp</td>
<td>100% amp</td>
</tr>
<tr>
<td></td>
<td>*58% amp</td>
<td>*100%</td>
<td>*58%</td>
<td>*100%</td>
</tr>
</tbody>
</table>

*Prevalence of amputations within each wound category

**% wound prevalence by grade and stage**
### Wagner Scale for Diabetic Foot Ulcers

- **Grade 0** - Pre-ulcerative lesion, healed ulcer or presence of bony deformity
- **Grade 1** - Superficial ulcer without subcutaneous tissue involvement
- **Grade 2** - Ulcer penetration through subcutaneous tissue, may expose bone tendon ligament or joint capsule
- **Grade 3** - Presence of osteitis abscess or osteomyelitis
- **Grade 4** - Gangrene of Digit
- **Grade 5** - Gangrene requiring disarticulation

### Charcot Foot

- **Mild trauma**
- **Increased pulse – Red and Hot** : TX non wt bearing if continuous ambulation then get dissolution of the metatarsals “pointed peppermint sign”
- **Fracture and Collapse of Foot – Rocker bottom deformity** - Tx molded shoes
- **Plantar ulcer develops**
Debridement of diabetic ulcers

- All necrotic and fibrotic tissue should be debrided down to healthy bleeding tissue
- Allows for extraction of foreign bodies
- Enzymatic debridement when minimal debris is present in wound
- Use caution with autolytic debridement
- Avoid whirlpool unless using as an aid for debridement of heavily necrotic areas
- Low threshold for X-rays - you’ll be surprised

Treatment for Neuropathic ulcer Disease

- Debridement of all Callous - Especially if drainage present
- Antibiotics if Infection is present
- Offloading orthotics, healing shoe etc.
- Frequent Debridement of wound edges
- Use of advanced wound care after ulcer bed free of necrotic tissue
Treatment of Active Infection

- Check Vascular status (remember previous chart and prognosis)
- Check Sensation
- Debride, Debride, Debride
- Offload
- Treat Infection outpatient if good blood flow and no signs of systemic illness
Why are Diabetics prone to foot infections?

- Ulceration and vascular status
- Hyperglycemia
  - Impairs migration, phagocytosis, intracellular killing, and chemotaxis
    - Ketosis impairs leukocyte function
- Deficient cellular immune response
The result...

- Colonization of dermis – Staph, Strep, fungi
- Poor granuloma formation
- Prolonged persistence of abscesses
- Impaired wound healing (various reasons)

Initial Empiric Antibiotic Selection

- Acute problem less than 2 weeks – coverage for Strep and Staph (beware of CA-MRSA)
- Acute on Chronic – Cover for Strep and Staph but beware of gm neg organisms and anaerobes
Appropriate Topical Therapy

- Debride necrotic tissue
- Identify and eradicate infection: reduce wound contamination
- Obliterate dead space
- Absorb excess drainage
- Maintain moist wound environment
- Provide thermal insulation
- Protect the wound from bacteria and trauma
- Promote wound healing

Debridement

- If vascular flow “OK” then be **aggressive**
  - especially if inpatient BUT DON’T LET THEM WALK OUT OF OFFICE IF YOU HAVE NOT ADDRESSED OFFLOADING!!!!!
- Diabetic foot wounds heal much faster if debrided aggressively – all providers should be comfortable with a scalpel or curette in the office.
- Callous should remind you for the need of offloading
Options for Non-Surgical Debridement

- Mechanical
- Autolytic
- Biotherapy
- Enzymatic (Chemical)

Biotherapy Debridement

- Biotherapy describes the use of live organisms (maggots) to assist in the medical regimen
Enzymatic Treatment Options for Necrotic Wounds

- COLLAGENASE SANTYL® OINTMENT,

Debridement cont.

- Mechanical – whirlpool/pulse lavage/jet-ox etc
  - What is the goal and stop when once achieved
- Autolytic – (does the patient have enough of an immune system to do this?)
Clinical Presentation

Critically Colonized
- Bioburden
- ↑ Bacterial Burden
- Local Wound Infection

Delayed healing
Change in color of wound bed
Friable granulation tissue
Absent or abnormal granulation tissue
↑ or abnormal odor
↑ serous drainage
↑ pain at wound site

“Secondary” Signs & Symptoms

Topical Antimicrobials - Silver

• Centuries of proven antimicrobial activity
• Cytotoxicity concerns associated with carriers not silver - ex. Silver nitrate, Silver sulfadiazine\textsuperscript{15}
• Traditional delivery required repeated applications due to binding with chlorine and proteins
• Contemporary silver dressings allow for continued release up to 7 days
• Broad spectrum - inactivates almost all known bacteria including MRSA and VRE\textsuperscript{15}
• No documented cases of bacterial resistance\textsuperscript{15}

\textsuperscript{15}Demling and DeSanti (2001)

Cadexomer Iodine

• Iodine is a well known antimicrobial agent
• 0.9% iodine is carried in polysaccharide beads
• Provides a slow sustained release of iodine in non-cytotoxic concentrations
• High rate of absorption from exuding ulcers.
• No documented cases of bacterial resistance.
DM foot s/p great toe amputation
no ABI done before procedure

- ABI and TCOM/s done – severe PVD
- Angiography with PTCA and stent to bilat SFA occlusions – normal ABI and TCOMs 2 weeks post procedure
- Then Debridement and attempted primary closure – failed because of MRSA
- MRSA treated and VAC to granulate wound in

Toxicity index for wound and skin cleansers

<table>
<thead>
<tr>
<th>Test Agent</th>
<th>Toxicity Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shur Clens®</td>
<td>1:10</td>
</tr>
<tr>
<td>Biolex™</td>
<td>1:100</td>
</tr>
<tr>
<td>Saf Clens™</td>
<td>1:100</td>
</tr>
<tr>
<td>Cara Klenz™</td>
<td>1:100</td>
</tr>
<tr>
<td>Ultra Klenz™</td>
<td>1:1,000</td>
</tr>
<tr>
<td>Clinical Care™</td>
<td>1:1,000</td>
</tr>
<tr>
<td>Uni Wash®</td>
<td>1:1,000</td>
</tr>
<tr>
<td>Ivory Soap® (0.5 percent)</td>
<td>1:1,000</td>
</tr>
<tr>
<td>Constant Clens™</td>
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<tr>
<td>Dermal Wound Cleanser</td>
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<td>Puri-Clens™</td>
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<td>Betadine® Surgical Scrub</td>
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<tr>
<td>Techni-Care™ Scrub</td>
<td>1:100,000</td>
</tr>
<tr>
<td>Bard™ Skin Cleanser</td>
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</tr>
<tr>
<td>Holister™</td>
<td>1:100,000</td>
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</tbody>
</table>

a The dilution required to maintain white blood cell viability and phagocytic efficiency. Source: Foresman, Payne, Becker, et al., 1993.
Adjunctive Treatments

- Regranex
- OASIS – active cellular matrix from pig small intestine
- Dermagraft – Neonatal Cultured Fibroblasts
- Apligraf – Bi-layered Cultured Dermis, Epidermis
- Hyperbaric Oxygen
  - Wagner 3 or greater despite 30 days of conventional good wound care
  - Vascular status checked first
Reminders

- Debrided Calluses off Ulcers heal by skin migration from wound edges and granulation - need to keep heaped up wound edges to a minimum
- Treat infection if signs present after debridement
- Dry wound bed heals much slower than a moist wound bed - new epithelial tissue has to "burrow" under scab/eschar so use moist wound healing dressing
- Offload with something
- Diabetic control
- Follow frequently until ulcer completely epithelized

Patient Guide to Foot Care

- Take care of your Diabetes
- Check your feet every day
- Wash your feet every day
- Keep your skin soft and smooth
- Smooth corns and calluses gently
- Have toenails trimmed regularly
- Wear Shoes and Socks at all times
- Protect you feet from hot and cold
- Keep the blood flowing to your feet
- Be more active
- Check with your doctor
- Get started NOW.