

# CASE STUDY

## ADAPTIC TOUCH® ON SKIN TEAR

### SECTION 1 – PATIENT DEMOGRAPHICS

#### 1.1 Age/Gender:

Patient is an 88 year old female.

#### 1.2 Pertinent medical history:

Patient is non-diabetic with history of hypertension, cardiac disease, gout, osteoarthritis, documented venous stasis disease, and basal cell cancer. She has palpable dorsalis pedis pulses bilaterally and they are triphasic by doppler, her posterior tibial pulses are not palpable due to edema, but they are biphasic on right and triphasic on left. Her lower extremity skin is dry, scaly, hyperpigmented, edematous and warm with two second capillary refill.

### SECTION 2 - WOUND CHARACTERISTICS

#### 2.1 Wound type and location

Traumatic wound on left knee and anterior tibia.

#### 2.2. Previous medical intervention/procedures

Patient was sent directly from the Emergency department after a fall, and presented with a significant skin tear across the left knee and anterior tibia. The skin flap was intact on arrival, however it was 'dusky' in appearance and the edges were rolled under.

#### 2.3 Description of wound including its size:

The wound dimensions were 13.3cm x 8.2cm x 0.2cm which include the entire open and ecchymotic area.

#### 2.4 Physical appearance:

The wound presents with a red, granular, underlying wound base with a dusky ecchymotic skin flap with rolled under edges.



Wound as presented at clinic on 09.12.2011

# CASE STUDY

## SECTION 3 – TREATMENT REGIME

### 3.1 State goal of therapy and main issues:

The initial objective was to irrigate the wound of any foreign material leftover from the fall (or other injuring insult) as well as to moisten beneath the flap for easier manipulation. Irrigation was conducted using 18-20 gauge angiocath and Normal Saline. The next step was to ‘tease’ methodically, gently, and patiently the flap of skin back into place using forceps (tips and flat back), gauze, and cotton tip applicators. Finally the distal edges of the flap were unfurled to keep them viable. These areas were secured with Steristrips without Mastisol.

### 3.2 Describe treatment options.

After steristrips were positioned, use a silicone based non-adherent contact layer (i.e. ADAPTIC TOUCH). Silicone is slightly ‘tacky’ which may help to maintain the position of the flap and its edges until the next dressing change. In this clinician's opinion, this helps to reconstitute capillary blood flow and decrease further shearing injury. Cover this non-adherent with a foam (to help with absorption and wound temperature regulation) followed by roll gauze and very light compression (i.e. tubular bandage).

### 3.3 List any additional intervention

Dependent on the injury and patient indication one may want to use ‘double’ tubular bandage to help control edema and increase chance of ‘skin flap’ adherence as well as light skin flora antibiotic coverage (i.e. Keflex)



Wound with ADAPTIC TOUCH®  
09.15.2011



Wound after a week of treatment with  
ADAPTIC TOUCH® 09.22.2011

# CASE STUDY

## SECTION 4 - CLINICAL OUTCOME

### 4.1 Summarize treatment

Dressings were changed twice weekly for the initial 2 weeks, to assess for infection and 'take' of patient's skin flap. At some of these visits steristrips may have been replaced or removed. The silicone non-adherent, and the outer dressing were changed. The clinic performed these dressing changes to decrease the chance of shearing injury to the healing skin flap. Patient is not allowed to shower or remove dressings as to allow for angiogenesis between wound bed and flap and not disturb adherence.

### 4.2 State total length of treatment

Approximately 1 month for COMPLETE healing.

### 4.3 State whether clinical outcome matched the goal of therapy.

The goal of the therapy was achieved. The Silicone non-adherent contact layer (in this case ADAPTIC TOUCH<sup>®</sup>) has been this patient's new dressing of choice, as well as that of many of our elderly 'fragile' skinned patients.



Wound at the end of treatment 10.17.2011

## SECTION 5 – CONCLUSION

### 5.1 Discuss your personal experience in treating the wound

This has been a great educational experience for me to see this type of significant flap re-adhere. I have since re-educated physicians in our clinic with the same procedure and we have accelerated healing significantly for these types of patients & wounds.

**5.2 Patient perspective i.e. quality of life issues.** We are starting to educate patients and families on how to treat their own small skin tears if they occur. For example: 1. Rinse with saline 2. Move the skin flap back over the open wound 3. Cover with ADAPTIC TOUCH<sup>®</sup> and gauze 4. Leave in place for 3 days.

### 5.3 Clinical benefits of using this particular product

In this clinician's experience, this product helps to keep skin flaps and natural grafts in place without adding too much moisture.

### 5.4 Discuss any cost implications

If these flaps can be repaired, the patient is potentially saved a chronic wound and many months in the wound center.