

Evaluation of Kliniderm Silicone Wound Contact Layer on patient with T-Cell lymphoma being treated with total skin electron beam therapy.

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Introduction

74 year old female, known T-Cell Lymphoma. She had been treated with total skin electron beam therapy resulting in erythrodermic and cracked peeling skin predominantly affecting the inner arms the back of her legs and trunk. She had been an inpatient due to her ongoing treatment but was readmitted due to the radiotherapy reactions to the medical assessment unit and referral was made to tissue viability and palliative care for assessment of wounds.

1st Assessment

Patient had extensive radiotherapy reactions to inner arms, back of legs and trunk. She was in severe pain and required sedation before assessment and dressing of wounds could begin. We were concerned due to the overall condition of her skin and required a non adherent flexible dressing that would prevent further trauma. Due to the nature of the wounds and the risk of infection Flamazine was used under the primary dressing, the dressing chosen was Kliniderm Silicone Contact Layer to ensure dressings would not adhere to raw areas and any exudate could pass through to prevent any maceration and potential deterioration to extremely friable skin, burns gauze was used as secondary dressing. Dressing changes were initially needed daily.

2nd Assessment

4 days later we reassessed wound which had been changed daily by ward staff following our care plan, the skin was improving and patient no longer required sedation. Wounds to the back of her legs and inner arms had reduced in size by approximately 50% and epithelisation was evident, improvement in the wound bed was also seen on the trunk. Patient did not experience any pain whilst wearing the dressing and they were easily removed causing no further discomfort for the patient. Dressing changes reduced to alternate days.

3rd Assessment

A further 2 dressing changes (4 days later) patient was reassessed. Reduction by approximately 80% seen on trunk and inner arms and backs of legs had healed. Patient very happy with dressing and felt no discomfort during dressing changes. Continued with alternate days due to areas being dressed and difficulty keeping dressings in situ.

4th assessment

At 6th dressing change (3 days later) patient was reassessed by tissue viability. Patient's wounds had fully healed.

Conclusion

Kliniderm Silicone Contact Layer was used as primary dressing for a total of 11 days. The dressing did not cause any trauma or adhere to any fragile skin, was found comfortable to wear by patient and was very easily removed on dressing change. The number of dressing changes were able to be reduced within the first 4 days, they were then kept at alternate days due to the position of the wounds and the limitations of keeping any dressings in situ on these areas. Kliniderm Silicone Contact Layer did not cause any maceration and handled the transfer of exudate well.