



North East Specialized
Geriatric Centre
Centre gériatrique
spécialisé du Nord-Est

Date: Jan 15, 2019

PLEASE NOTE that Project ECHO® Care of the Elderly case recommendations do not create or otherwise establish a provider-patient relationship between any ECHO Care of the Elderly Hub team member/presenters and any patient whose case is being presented in a Project ECHO® setting.

All resources are posted in the COP website, under “Jan 15 - Pressure Injuries”. You must be logged in to view the resources.

Case Synopsis:

50-60 year-old female with diabetes, obesity and current smoker, admitted to the home from a psychiatric facility showing 5 scabbed areas on left lower leg (largest 8mm) and two scabbed areas on R ankle (largest 5mm) on right ankle on admission. Legs were edematous, non-pitting to mid tibia region. Scale. Started treatment for stasis dermatitis including moisturizer treatments, tubigrip stockings, and elevation of legs. Weekly wound care assessments.

Q1 When mobility and transportation are an issue for a LTC resident, how confident are you in starting compression therapy prior to obtaining vascular studies to confirm arterial patency?

Q2 Who is usually spearheading the wound care team/program at your LTC home? What are the frequency of assessments?

Summary of Recommendations:

Further workup/investigations:

1. Obtain portable ABI equipment and training for LTC staff. ABI results should be considered for potential inaccuracy for calcified pulses. Need to also establish if pt can tolerate this procedure.
2. If no equipment is available, is it possible to perform clinical assessment of pulses? If there are pulses present, the patient can usually tolerate mild compression such as tubigrip which is about 8-12mmHg. Sometimes you cannot feel pulse due to edema, trial of mild compression can be done with care/monitoring.
3. Find out if mobile Doppler studies are available in your area and if testing can be performed in the LTC home.
4. Order albumin level as a broad prognostic indicator. However, it may be low as it is acute phase reactant.
5. Use Levine method to collect wound swab by cleansing the area first with normal saline, pressing the swab in a clean area rotating about 360 degrees and pressing down on the swab when obtaining the culture to express wound fluid from viable tissue. This will give you a result closer to a tissue culture rather than just all the bacteria on the surface.



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Non-Pharmacological interventions:

1. Consider nutritional supplementation to support wound healing by increasing protein intake. There is no evidence to support the benefit of a particular type of protein but increasing it seems to help wound healing.
2. Use facecloth to gently remove excessive dry skin to peri wound as the patient cannot do it and there is often bacteria in the dead skin.
3. Consider using Betamethasone to treatment itching of peri wound. Venous stasis dermatitis can lead to the patient picking at the wounds.
4. Consider reevaluating what wound care products are used in the home as there is not randomized control studies to support expensive, specialized wound care products and being a part of this discussion with LTC leadership.
5. Training of nursing staff to ensure consistent wound management is essential

Pharmacological interventions:

1. Consider discontinuing pregabalin, gabapentin or amlodipine as they may cause edema
2. There is not good evidence to use Vit C and Zinc supplementation however, it is often used.
3. There is some good evidence to use pentoxiphyline for lipodermatosclerosis (hardening of the tissue due to long standing edema). Should be used with compression and may have side effects (GI).
4. Use a diuretic if other alternatives have been exhausted though this will only help short term as the leg problem is a LOCAL issue. The patient may become dehydrated. Not ideal.

Resources:

1. Long-Term Care Homes Act and its mandates on wound care (section 50)
 - o <https://www.ontario.ca/laws/regulation/r10079#BK58>