Active Leptospermum Honey and a Super-Absorbent Hydrogel-Colloidal Sheet in Managing Challenging Lower Extremity Wounds: A Case Study Series


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INTRODUCTION

In the United States, several healthcare systems and organizations have used the Active Leptospermum Honey and the Super-Absorbent Hydrogel-Colloidal Sheet in managing challenging lower extremity wounds. Case studies are presented focusing on healing times along with additional studies using HCS as an active ingredient.

CONCLUSION

In evaluating the outcomes, it is evident that even with the varied populations, wound types, and co-morbidities, wound healing was achieved. Furthermore, the addition of ALH with HCS, despite having been non-healing in previous trials, demonstrated improved wound closure. Decrease in maceration or necrosis was accomplished in all cases where ALH and HCS were used. Patients with foot ulcers, venous ulcers, or chronic wounds benefitted from the use of HCS. Further research is suggested with a micro-homogeneous group focusing on healing times along with additional studies using HCS on the primary dressing.

Case 1

Patient was a 70 y/o with co-morbidities: CHF stage 2, complete heart block after aortic valve replacement, HTN, sleep apnea, ischemic cardiomyopathy, IDDM, neuropathy, depression, and dementia. She was a 72 y/o with co-morbidities: CHF stage 2, complete heart block after aortic valve replacement, HTN, sleep apnea, ischemic cardiomyopathy, IDDM, neuropathy, depression, and dementia. She was seen by vascular surgeon and had 2nd fitting for prosthesis 10/20/11. Dressing was approved. She was also on insulin, oral antibiotic and cardiac meds. Ulcer developed on right foot L. ankle. Pain 5/10 intermittent, 3 + pitting leg edema was more pronounced in the foot. Pt returned to work. Pt healed in 16 days with ALH paste and calcium alginate dressings. Pt was also started on Co Q10 Coenzyme topically until ulcer became necrotic. On initial visit, minimal sign of a pre-existing ulcer, no maceration, and no pain. Pt returned to work. Ulcer healed 100% in 21 days with dressing change 2 x per wk.

Case 2

Patient was a 56 y/o with co-morbidities: CHF stage 2, complete heart block after aortic valve replacement, HTN, sleep apnea, ischemic cardiomyopathy, IDDM, neuropathy, depression, and dementia. She was admitted to the hospital 9/30/11-10/3/11 due to traumatic wound in L. anterior leg acquired since age 9, frequent hypoglycemic episodes due to not eating, forgetfulness/questionable memory, and medication non-compliance. Pt was admitted with 70% yellow slough, 30% granulation tissue and small to moderate amount of serous exudate. Notice pressure caused by sleeping on ulcer. Pt was seen by vascular surgeon and had 2nd fitting for prosthesis 10/20/11. Dressing was approved. She was also on insulin, oral antibiotic and cardiac meds. Ulcer developed on right foot L. ankle. Pain 5/10 intermittent, 3 + pitting leg edema was more pronounced in the foot. Pt returned to work. Pt healed in 16 days with ALH paste and calcium alginate dressings. Pt was also started on Co Q10 Coenzyme topically until ulcer became necrotic. On initial visit, minimal sign of a pre-existing ulcer, no maceration, and no pain. Pt returned to work. Ulcer healed 100% in 21 days with dressing change 2 x per wk.

Case 3

Patient was a 56 y/o with co-morbidities: CHF stage 2, complete heart block after aortic valve replacement, HTN, sleep apnea, ischemic cardiomyopathy, IDDM, neuropathy, depression, and dementia. She was admitted to the hospital 9/30/11-10/3/11 due to traumatic wound in L. anterior leg acquired since age 9, frequent hypoglycemic episodes due to not eating, forgetfulness/questionable memory, and medication non-compliance. Pt was admitted with 70% yellow slough, 30% granulation tissue and small to moderate amount of serous exudate. Notice pressure caused by sleeping on ulcer. Pt was seen by vascular surgeon and had 2nd fitting for prosthesis 10/20/11. Dressing was approved. She was also on insulin, oral antibiotic and cardiac meds. Ulcer developed on right foot L. ankle. Pain 5/10 intermittent, 3 + pitting leg edema was more pronounced in the foot. Pt returned to work. Pt healed in 16 days with ALH paste and calcium alginate dressings. Pt was also started on Co Q10 Coenzyme topically until ulcer became necrotic. On initial visit, minimal sign of a pre-existing ulcer, no maceration, and no pain. Pt returned to work. Ulcer healed 100% in 21 days with dressing change 2 x per wk.

Case 4

Patient was a 56 y/o with co-morbidities: CHF stage 2, complete heart block after aortic valve replacement, HTN, sleep apnea, ischemic cardiomyopathy, IDDM, neuropathy, depression, and dementia. She was admitted to the hospital 9/30/11-10/3/11 due to traumatic wound in L. anterior leg acquired since age 9, frequent hypoglycemic episodes due to not eating, forgetfulness/questionable memory, and medication non-compliance. Pt was admitted with 70% yellow slough, 30% granulation tissue and small to moderate amount of serous exudate. Notice pressure caused by sleeping on ulcer. Pt was seen by vascular surgeon and had 2nd fitting for prosthesis 10/20/11. Dressing was approved. She was also on insulin, oral antibiotic and cardiac meds. Ulcer developed on right foot L. ankle. Pain 5/10 intermittent, 3 + pitting leg edema was more pronounced in the foot. Pt returned to work. Pt healed in 16 days with ALH paste and calcium alginate dressings. Pt was also started on Co Q10 Coenzyme topically until ulcer became necrotic. On initial visit, minimal sign of a pre-existing ulcer, no maceration, and no pain. Pt returned to work. Ulcer healed 100% in 21 days with dressing change 2 x per wk.

Case 5

Patient was a 56 y/o with co-morbidities: CHF stage 2, complete heart block after aortic valve replacement, HTN, sleep apnea, ischemic cardiomyopathy, IDDM, neuropathy, depression, and dementia. She was admitted to the hospital 9/30/11-10/3/11 due to traumatic wound in L. anterior leg acquired since age 9, frequent hypoglycemic episodes due to not eating, forgetfulness/questionable memory, and medication non-compliance. Pt was admitted with 70% yellow slough, 30% granulation tissue and small to moderate amount of serous exudate. Notice pressure caused by sleeping on ulcer. Pt was seen by vascular surgeon and had 2nd fitting for prosthesis 10/20/11. Dressing was approved. She was also on insulin, oral antibiotic and cardiac meds. Ulcer developed on right foot L. ankle. Pain 5/10 intermittent, 3 + pitting leg edema was more pronounced in the foot. Pt returned to work. Pt healed in 16 days with ALH paste and calcium alginate dressings. Pt was also started on Co Q10 Coenzyme topically until ulcer became necrotic. On initial visit, minimal sign of a pre-existing ulcer, no maceration, and no pain. Pt returned to work. Ulcer healed 100% in 21 days with dressing change 2 x per wk.

Case 6

Patient was a 56 y/o with co-morbidities: CHF stage 2, complete heart block after aortic valve replacement, HTN, sleep apnea, ischemic cardiomyopathy, IDDM, neuropathy, depression, and dementia. She was admitted to the hospital 9/30/11-10/3/11 due to traumatic wound in L. anterior leg acquired since age 9, frequent hypoglycemic episodes due to not eating, forgetfulness/questionable memory, and medication non-compliance. Pt was admitted with 70% yellow slough, 30% granulation tissue and small to moderate amount of serous exudate. Notice pressure caused by sleeping on ulcer. Pt was seen by vascular surgeon and had 2nd fitting for prosthesis 10/20/11. Dressing was approved. She was also on insulin, oral antibiotic and cardiac meds. Ulcer developed on right foot L. ankle. Pain 5/10 intermittent, 3 + pitting leg edema was more pronounced in the foot. Pt returned to work. Pt healed in 16 days with ALH paste and calcium alginate dressings. Pt was also started on Co Q10 Coenzyme topically until ulcer became necrotic. On initial visit, minimal sign of a pre-existing ulcer, no maceration, and no pain. Pt returned to work. Ulcer healed 100% in 21 days with dressing change 2 x per wk.