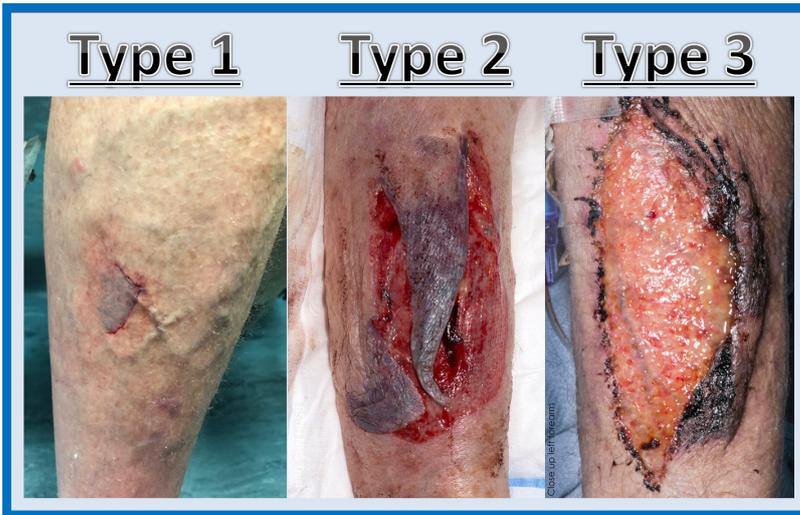


# Initial Management for Pre-tib Lacerations



**Type 1:** Minimal or no skin loss. Skin can be fully replaced over wound bed.

**Type 2:** Partial skin loss. Some skin can be replaced over the wound bed.

**Type 3:** Total skin loss. No skin available for replacement

Control and stop bleeding

Assess and clean wound with appropriate cleaning solution (e.g prontosan or saline)

Identify the type of laceration (1, 2 or 3) and re-approximate the flap if able. A damp gauze placed over the skin flap can be used to rehydrate skin flaps if required. Non-viable skin should be debrided.

Moisturise peri-wound skin, then apply silicone based dressing (e.g. Silflex) anchoring one side to undamaged skin, and hold the skin flap in place. **There is no need to use steri-strips** as the adhesive nature can result in further trauma.

Apply a secondary dressing to manage the exudate. A super absorber (e.g kerra max care) is best suited, gauze is also sufficient in lower exuding wounds.

Finally bandage leg from **toe to knee**, using soft band as the first layer of bandage and applying k-lite or crepe as the secondary bandage layer. An additional layer of tubular bandage can be added for extra security to secure the bandage if needed.

## Dressing Selection for Pre-tib lacerations

### Discontinuing the use of 'steri strips' and suturing

The choice of dressing applied to an acute pre-tib laceration can lengthen or shorten the healing time of that laceration.

The use of steri-strips to hold skin flaps in place may seem effective however the highly adherent nature of the dressing makes them painful for the patient and traumatic to the skin laceration on removal.

The inflexibility of the dressing places force on the surrounding tissues decreasing the chances of the skin flap remaining viable and increasing the chances of wound deterioration.

Suturing pre-tib lacerations has a similar negative effect. Fragile skin is unable to support the pressure from the sutures and can 'cheese wire', resulting in the sutures cutting through the skin flap. Suturing the laceration doesn't allow for swelling of the area and increased tension results in poor wound healing.



### Benefits of a Silicon based dressing

Silicon dressings (such as SILFLEX) are both easy to apply and gentle in nature. The coating is slightly 'tacky' in nature but contains no adhesives. The silicon can be anchored to unbroken skin and placed over the skin laceration to hold the skin flap in place.

Application is painless, flexible and effective for the patient and quick and cost effective for the health care provider. It provides a secure but not aggressive retention of the skin flap and reduces the chances of sheering from unsecure dressings, optimising the quality of life for the patient.

The wear time of the dressing depends on the wound environment. Higher exuding dressings will need more frequent changes whereas lower exuding wounds are able to be left longer before changing. The recommended wear time is 3-7 days however SILFLEX is licenced for up to 14 days. Allowing ample time for follow up to be arranged.

Skin flaps benefit from undisturbed period of time to be able to adhere to the wound bed and act as a biological 'dressing' to reduce the size of the wound and promote faster wound healing.

### Secondary Dressings

Secondary dressings cover the primary dressing and manage the exudate from the wound. High exuding wounds require the use of a 'super absorber' which absorbs the exudate and holds it inside the dressing away from the skin reducing the risk of maceration. KerraMax Care (super absorber) is available throughout the trust on the wound care formulary.

For lower exuding wounds gauze can be used as a absorbent layer, these dressings will need changing at more regular intervals as gauze can dry out and become difficult to remove.



## Bandaging—Toe to knee

### First layer

The use of cotton soft band or k-Soft:

- Holds the dressings in place
- Distributes pressure
- Helps to shape the leg
- Soft and comfortable
- Extra resilience and cushioning

Note that the heel is encompassed in the dressing to improve protection while resting the limb.



### Second Layer

The use of k-Lite or crepe bandaging

- Holds the dressings in place
- Reduces swelling
- Encourages venous return
- Manages swelling
- Element of compression is beneficial to lower limb healing.

Bandaging should always be completed from the toe to the knee to best aid venous return, reduce swelling and tourniquet effect.

A stocking can be placed over the top of these bandages to aid keeping them in place for patients who are more active or have restless legs.

### Importance of toe to knee bandaging

Limbs that are not bandaged toe to knee are left susceptible to a tourniquet effect, where one area is allowed to swell and another is compressed by the bandage. In some cases the increased swelling in these areas can result in pressure damage to the surrounding tissues and leave patients with further wounds.

Some patients may be reluctant towards a toe to knee bandage but it is essential that as health care professionals we help educate on the importance of correct support for the limb.

