Introduction
The Eastbourne Wound Healing Centre concentrates on ‘treatment’ rather than ‘management’ of wounds. However, the case of Mrs C was particularly difficult because the treatments, such as compression therapy, were not tolerated by the patient, leaving only ‘management’ available to the nurse.

The undisputed optimum treatment for venous leg ulcers is compression therapy. However, this is not always acceptable to the patient; the problem is rarely just the wound but its associated problems such as pain, odour, or (as in this case) high exudate – which has a great impact on quality of life. This case study review shows the particular problem of high exudate was overcome in the case of Mrs C.

Effects of excess exudate
A vital part of wound healing is the control of exudate, to create the ideal moist wound environment. Excess exudate can result in harmful proteases increasing within the wound and delaying healing in the chronic wound (Phillips et al).

Where exudate is uncontrolled, the surrounding skin becomes macerated and excoriated, resulting in the wound edges breaking down and increasing the surface area of the wound. Damaged periwound skin is also at risk of infection, which in turn produces more exudate.

Control of exudate
Compression helps to reduce the production of exudate, but it is not suitable or tolerable for all patients.

One simple method of reducing exudate and odour is to reduce the bacterial content of a wound with an antimicrobial or absorbent dressing. Flivasorb is a superabsorbent dressing which acts as a protease modulator by absorbing excess exudate and proteases, locking them into the dressing. This performs a dual function of controlling the exudate and removing the harmful proteases that delay wound healing.

The Case Study
Mrs C is a relatively young woman of 58 who is obese and has some difficulty with mobilising, but still works in her own shop. She was unable to tolerate compression and many of the commonly used dressings. This made selecting an acceptable dressing challenging.

Rationale for dressing selection
Flivasorb was selected as a superabsorbent dressing which locks exudate into the dressing, whilst maintaining a moist wound environment. It has a blue top layer designed to protect the wearer’s clothes and bedding. The dressing was flat and flexible when applied and felt comfortable to Mrs C. A retention bandage held it in place.

The dressing’s performance was monitored over a 2 week period and the dressing was changed twice a week.

Results
On removal of the dressing the Flivasorb appeared to have drawn the exudate away from the wound surface, leaving it moist but not wet (Figure 5). The dressings successfully controlled the exudate and Mrs C felt more confident at work. Flivasorb locked the fluid into the dressing and prevented maceration at the wound margins.

The next step
The next aim of the treatment was to eliminate and control the proliferation of bacteria in the wound.

Rationale for dressing selection
It was decided to try a new antimicrobial dressing, Suprasorb X+PHMB (Polyhexamethylene biguanide or polyhexanide). The dressing is indicated for critically colonised and infected wounds. PHMB has been in use since 1959 in swimming pools, contact lens cleaning solutions and cosmetics. It was felt appropriate to use it on Mrs C as it is very well tolerated and suitable for long term use.

A secondary foam dressing was also used.

Results
Devascularised tissue was removed.

Conclusion
It should be recognised that the dressings are not necessarily the answer when it comes to the management of wounds. We must first address the main barriers to healing, but if the patient is unable to tolerate the removal of those barriers, then alternative choices must be made available as in Mrs C’s case.