EB WOUND CARE BASICS

EB wound needs can be complex and need to be tailored to each patient. Depending on type/sub-type of EB wound presentation can be variable.

EB wound presentation depends on both wound and host factors:

Wound factors: size of area involved, location, and presence of bacterial colonization or infection[1]

Host factors: nutritional status, underlying genetic defect and predisposing factors (such as reduced range of motion and mobility)[1]

Basic equipment

- Sharp scissors to cut and trim bandages.
- Sterile needles for lancing blisters & gauze to wick away fluid.
- Bandages.
- Securement material (example: tubifast, conforming gauze).

Acute Wounds[1,2]

- Clean area with normal saline (pour) and gently pat dry.
- Apply topical medication as prescribed – use a tongue depressor to apply thinly and evenly on dressings – then apply the dressing to the skin.
- Silicone dressings are the best choice to cover acute wounds.
- Cover wound with selected dressing:
    - Contact layer (example: mepitel, Restore, etc.) requires a secondary dressing (example: telfa, foam, etc.), secure (silicone tape, cling, tubifast, etc.).
    - Ensure contact layer is flat on skin.
    - If using elastic securement ensure that it does not roll or touch skin (cut a few cm shorter than the edge of the dressing).
- Silicone dressings can be used for up to 7 days.
- DO NOT use tape on skin, if tape is needed use silicone tape.
- Demonstrate dressing application on an acute wound to the care givers or patient.
- If the dressing sticks to the skin reassess the dressing being used.
- DO NOT remove dressings that are stuck to the skin – soak with normal saline for approximately 15 minutes or until you can feel that the dressing will come off without lifting the skin.
    - If Niltac is available use this to remove adhesive dressings (follow manufacturer's instructions).
- Avoid daily dressing changes – if wounds are clean and healing well daily dressing changes are not necessary.
- DO NOT use sensitizing topical antibiotics (example: Bacitracin) – speak to EB expert team if this is ordered.

1. *Lara-Corrales, I. et al. 2010. Principles of wound care in patients with Epidermolysis Bullosa. Pediatric Dermatology 27(30), pp. 229-237.*
2. *Disclaimer: Unless stated otherwise, information contained in this document is taken from Epidermolysis Bullosa: A Handbook for EB Patients and Families, Developed by the Section of Dermatology at the Hospital for Sick Children with the Support of DEBRA Canada and Sick Kids Hospital Department of Dermatology EB Expert Team - all content used with permission. This document was created by SWRWCP (August, 2019).*

EB WOUND CARE BASICS

Chronic Wounds[1,2]

- Chronic wound management is generally painful – pain control may be needed more frequently and not only for dressing changes.
- Carefully remove dressings
  - If dressings are stuck to the skin, soak with normal saline for about 15 min or until you feel the dressing will come off without lifting the skin or use Niltac.
- Very carefully assess area during each dressing change.
  - If odor, drainage, or increasing pain present the MRP may consider antibiotics.
  - If non-healing area looks worrisome a biopsy may be considered.
- Clean area with normal saline and gently pat dry.
- Apply the prescribed cream using a tongue depressor thinly and evenly on the dressing. Avoid antibiotics that are highly sensitizing and seek clarification if they are ordered.
- Apply dressing.
  - Silicone dressings are the best choice
  - If wound presents crusted / dry areas consider hydrogels to provide moisture
  - If wound has lots of exudate select dressings that provide absorption to avoid maceration
  - With infected chronic wounds silver dressings may be ordered
  - Secure dressings with Cling or burn net
- In highly exudative chronic wounds dressing changes may be required more frequently than with dry wounds (daily vs every 3–7 days).
- In chronic wounds with hypergranulation tissue, patients may benefit from short course of high potency topical steroids to reduce inflammation. If these are used, monitor patients closely.

Dressing types and Characteristics[1,2]

Categories	Dressings/Other	Notes
Silicone Medical Adhesive Remover	• Niltac spray	To remove adhesive dressing off skin
Hydrogels	• Intrasite gel	• For wounds with minimal to no exudate • Due to hydrating capacity, can provide cooling sensation and may aid in relief of pain, itchy, and discomfort
Contact Layer	• Intrasite Conformable • Mepitel One • Urgotul • Urgotul AG • Vaseline Gauze Strips	• Contact layer to provide non-traumatic removal • Reduces pain and trauma during dressing changes. • Clings and conforms to all body contours.

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		Foam / Absorptive layer	• AMD disc • Mepilex • Mepilex Lite • Mepilex Border • Mepilex Border Lite • Mepilex Border AG • Mepilex Transfer • PolyMem • PolyMem AG • Telfa	• Absorbs wound fluid • Provides padding and protection • May require secondary dressing • Bordered dressings may be too sticky – use with caution • Bordered dressings for isolated wounds • Poor absorption of highly viscous exudate • PolyMem can stimulate increased exudate – protect periwound • *AG = silver – for locally infected wounds	
		Superabsorbant	• Mesorb	• Used in highly exudative wounds • Can stick to skin if contact layer not used	

Useful Websites/links:

- www.swrwoundcareprogram.ca
- EB Resources, including EB handbook: https://www.debracanada.org

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