

The use of a soft silicone wound contact dressing (Silflex®) under topical negative pressure dressing

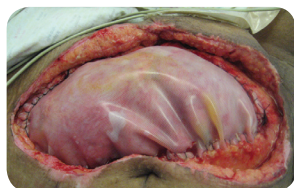
Kumal Rajpaul & Bernadette Byrne - Tissue Viability Nurse Specialists, Kings College Hospital, London

The open abdomen poses a complicated process of management with various treatment objectives such as delayed primary closure, repeated entries into the abdominal cavity or to allow healing by secondary intention.

The management of this can further be complicated with exposure of bowels or omentum. At times silastic meshes or saline bags (bogota bag) are sutured to the abdominal wall to hold the contents of the abdomen in place.

Case study I

Shows a dehiscence abdomen initially with a silastic mesh in-situ however the surgical team requested that a non adherent silicone dressing be used to line the wound prior to topical



negative pressure therapy (TNPT) being applied.

The patient had a traumatic tearing/ bursting of scar tissue to a healed laparotomy site after sneezing without wearing a

corset at the time of the incident. There was evisceration of small bowels through the abdomen scar tissue.

The patient underwent a laparotomy and replacement of the abdominal contents with a silastic mesh applied. One day post operatively the wound measured 27cm x 15.5cm with a deep



silastic mesh. The wound edges appeared healthy.

Silflex® soft silicone wound contact dressings were applied as a primary protective non-adherent layer.

Topical negative pressure therapy was applied at 125mmHg continuous therapy. This was changed every seventy-two hours.



As the oedema was reducing the number of Silflex® soft silicone wound contact layers decreased to two.



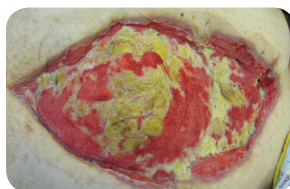
With the reduction in oedema and contraction of the wound it was necessary to cut the non-adherent layer to the shape of the wound.

Prior to discharge into the community the wound had

reduced in size to 19cm x 10cm. The silastic mesh was lifting, as the wound was contracting/closing. This will be removed in the near future and TNPT would continue to facilitate healing by secondary intentions with Silflex® as a wound contact layer.

Case Study 2

An abdomen that was left open following an initial surgery for perforated diverticulum, with subsequent faecal peritonitis. This patient had several laparotomies after the initial surgery and a formation of stoma. The abdomen was left open due to the multiple entries required because of the nature of the condition.



The patient was referred to the Tissue Viability Team for management of the abdominal wound. The abdomen was grossly oedematous with copious amounts of serous exudate and unsuitable for primary closure. A bogota bag was in situ as a temporary abdominal closure method.

Once the bogota bag was removed an abdominal vacuum assisted closure dressing was initially used as local policy for the management of exposed bowels. Once granulation was achieved over the bowels Silflex®

was used as the primary non-adherent wound contact layer. The wound measured 25cm x 13cm.

First review after Silflex® application and TNPT. Wound size 23cm x 12cm. This will continue until the wound has re-epithelised.

The purpose of this poster was to evaluate the effectiveness of a soft silicone wound contact layer (Silflex®) under topical negative pressure therapy. It was non-adherent to the wound bed and atraumatic to the granulating tissue on removal. It was very easy and effective to use.