

Clinical Case Study

Treatment of Coumadin Tissue Necrosis with Silverlon

Wound Care Clinic

SwedishAmerican Hospital

Rockford, IL

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Problem: 74 year old male patient first seen at the Wound Care Clinic in March, 2001. Patient has insulin-dependent diabetes, venous stasis disease, hypertension, atrial fibrillation, congestive heart failure and is hard of hearing. His medications include insulin, Allopurinol, Lanoxin, Coumadin, Vasotec, KCL, Mag-Ox, Zaroxolyn, Demadex and a nitropatch. Allergies are to Levaquin.

Clinical presentation: Initially the patient had involvement of both lower legs with a rubor-like discoloration from his ankles to the knees. There is partial thickness tissue loss with friable periwound skin. Any manipulation of the skin results in bleeding. The areas of tissue loss have increased over time. The tissue has been cultured and biopsied. The general consensus is that the condition is related to coumadin use and may be clinically known as coumadin-induced tissue necrosis. Switching from the coumadin to another medication is not an option in this scenario. The challenge is to develop a topical routine to protect the skin, encourage healing, maintain healing and provide compression.

Topical Interventions: Various topical interventions have been tried including an Unna-type boot (Medicopaste and Coban), non-stick gauze, a thin foam and cotton padding and a tubular elasticated bandage for compression. Removal of even the most non-stick dressings has resulted in some form of local tissue trauma and new, bleeding areas.

On June 26, we began wrapping the right leg with Silverlon, cotton padding and the tubular elasticated bandage. The left leg treatment continued with non-stick and absorbant materials as well as the cotton padding and tubular elasticated bandage. The patient is seen two times per week for dressing changes. By July 2, 2001, the right leg was fully epithelialized with no open areas and no zones of friable tissue. The left leg was then wrapped with Silverlon, cotton padding and tubular elasticated bandage. The right leg was wrapped only with the cotton padding and tubular elasticated bandage. On July 9, 2001, the left leg was also fully epithelialized with no open areas and no zones of friable tissue.

Outomes: Both legs are fully epithelialized. Due to the involvement of the coumadin in this scenario, a long term treatment plan will include the use of Silverlon to any areas that open. We are now able to see the patient once a week and have begun preparing the patient for discharge from the clinic with a long-term care plan. The family will provide support with routine skin care, monitoring of the tissue integrity and compression application. The patient will be seen at the Wound Care Clinic as needed for periodic evaluation and management.



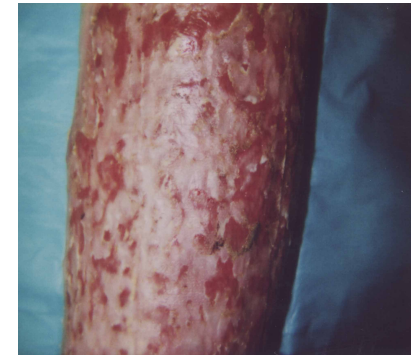
Right Leg 6/26/01
Silverlon® Started



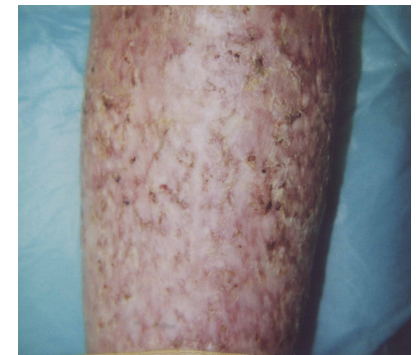
Right Leg 7/02/01
Wound Healed
Silverlon® Discontinued



Right Leg 7/30/01
1 Month Follow Up



Left Leg 7/02/01
Silverlon® Started



Left Leg 7/09/01
Wound Healed
Silverlon® Discontinued



Left Leg 7/30/01
3 Week Follow Up

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