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ORIGINAL ARTICLE

Tolerability and efficacy of hydrocolloid dressings in the treatment of venous leg ulcers under tropical conditions: an open prospective study

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ABSTRACT
In the Western world, hydrocolloid dressings are widely used in wound treatment. However, little is known about their tolerability and efficacy under tropical conditions. The purpose of this study was to assess the tolerability and efficacy of a hydrocolloid dressing in combination with short stretch compressive bandages under tropical conditions. Seventeen patients with venous leg ulcers attending an outpatient clinic in Surinam were enrolled in the study for a period of 6 weeks. Swabs for bacterial cultures were taken at the beginning and end of the study. All ulcers showed a good healing tendency. Percentage of granulation tissue in the ulcers improved from mean 27% at start to 92% at the end. Mean circumference at start was 9.9 cm, at the end 4.9 cm. Exudation diminished from moderate in six and severe in eight ulcers, to moderate in 10 and almost none in two ulcers. In general, the dressing was very well accepted, pain was never reported. Leakage was noticed 39 times in the 164 dressing changes. This study revealed no differences in the rate of bacterial infections or colonization of wounds compared with studies performed in temperate regions. Our data indicate that hydrocolloid dressings can be used under tropical conditions.

Key words: hydrocolloid dressing, tropical climate, venous leg ulcers

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Introduction
Several studies have shown that a moist environment favours wound healing.1–2 For this reason, many (semi)occlusive dressings have been developed. One of these dressings is the hydrocolloid dressing.3–8 These opaque, absorbent dressings consist of hydrocolloid granules embedded in an adhesive matrix covered by a polyurethane foam. In the Western world, these dressings are now widely used in the management of (leg) ulcers. However, little is known about their use under tropical conditions. Alleged increases in the frequency of wound infection may be an important reason that hydrocolloids are not used regularly under these conditions.9–11 One study performed in a south Indian hospital described good results in treating chronic ulcers mostly secondary to leprosy; however, no bacterial studies were performed.12

We studied the tolerability and efficacy of a hydrocolloid dressing for venous leg ulcers under humid tropical conditions.

Patients and methods
The study was performed in Paramaribo, which is the capital city of Surinam. It has a tropical climate with annual temperatures between 22.8 °C and 32.2 °C and more than 2032 mm of rainfall per year. The study was carried out during the rainy season with a humidity fluctuating at about 95%.

All patients received written and spoken information, and written informed consent was obtained. The study was approved by the local Ethics Committee.

Patients with a venous leg ulcer attending the outpatient clinic at the Department of Dermatology of the Academic Hospital Paramaribo in Surinam were included; the ulcers were less than 6 cm length and less than 4 cm wide and diagnosis was based on clinical signs for venous insufficiency; other diagnostic procedures were not available. Specific exclusion criteria were diabetes mellitus, congestive heart failure, malignancy or ankle/brachial index less than 0.75.
All ulcers were treated with a hydrocolloid dressing (Comfeel Plus Transparant® and Comfeel Plus Ulcer®, Coloplast, Humlebaek, Denmark) for a period of 6 weeks. Dressing and bandages (Elko®, Lohmann, Neuwied, Germany) were normally changed twice weekly, but more often when necessary. Short stretch bandages were applied. The bandages remained on day and night. All patients were mobile.

Evaluations were recorded at every visit until the end of the study or until the ulcer showed 100% granulation or complete re-epithelialization. Ulcer outline was traced on a transparent pouch and pictures were taken. The ulcer area was measured from the transparent pouch using a computer image analysis system. Clinical improvement was recorded by means of percentage of granulation tissue on a scale of 0%–100%. Nine ulcers showed complete granulation tissue at week 6 (Table 1).

Results

Gram stain used and/or incubation conditions were applied depending on the bacterial results of cultures taken before and at the end of the study are shown in Table 2. Seven of the 13 isolates of Haemolytic streptococci were resistant to tetracycline; no methicillin-resistant Staphylococcus aureus were resistant to tetracycline, and no Enterobacteriaceae were resistant to amoxicillin. Five of the 12 isolates of Enterobacteriaceae showed resistance to cefazolin. All the 12 isolates of Enterobacteriaceae were found to be resistant to gentamicin.

Discussion

In developing countries chronic leg ulcers present an important health problem. Ulcers caused by venous disease may play a strong role in the pathogenesis of leg ulcers. The present study has shown that the hydrocolloid dressings are effective and well tolerated in the treatment of chronic leg ulcers. The dressing system was easy to apply and patient comfort was maintained. The dressings were easy to handle and could be removed without causing pain. Patients described the dressing as comfortable and pain was never reported. Leakage of the dressing was noticed only 39 times in 520 dressing changes. Average weartime of the dressing was 3.2 days.

Table 1 Ulcer circumference and granulation tissue formation before and at the end of the study period

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Circumference at start (cm²)</th>
<th>Circumference at end (cm²)</th>
<th>% Granulation tissue at start</th>
<th>% Granulation tissue at end</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7.7</td>
<td>5.6</td>
<td>&lt;25%</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>9.3</td>
<td>2.8</td>
<td>&lt;25%</td>
<td>100</td>
</tr>
<tr>
<td>3</td>
<td>12.7</td>
<td>10.5</td>
<td>&lt;25%</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>13.5</td>
<td>7.7</td>
<td>&lt;25%</td>
<td>100</td>
</tr>
<tr>
<td>5</td>
<td>16.7</td>
<td>8.2</td>
<td>&lt;50%</td>
<td>&lt;50</td>
</tr>
<tr>
<td>6</td>
<td>10.3</td>
<td>2.3</td>
<td>&lt;25%</td>
<td>100</td>
</tr>
<tr>
<td>7</td>
<td>9.6</td>
<td>3.6</td>
<td>&lt;25%</td>
<td>100</td>
</tr>
<tr>
<td>8</td>
<td>8.2</td>
<td>3.3</td>
<td>&lt;25%</td>
<td>100</td>
</tr>
<tr>
<td>9</td>
<td>5.5</td>
<td>2.3</td>
<td>&lt;50%</td>
<td>100</td>
</tr>
<tr>
<td>10</td>
<td>6.9</td>
<td>closed, week 3</td>
<td>0</td>
<td>closed, week 3</td>
</tr>
<tr>
<td>11</td>
<td>6.2</td>
<td>5.8</td>
<td>&lt;25%</td>
<td>100</td>
</tr>
<tr>
<td>12</td>
<td>5.8</td>
<td>closed, week 4</td>
<td>0</td>
<td>closed, week 4</td>
</tr>
<tr>
<td>13</td>
<td>18.7</td>
<td>9.5</td>
<td>&lt;25%</td>
<td>&lt;75</td>
</tr>
<tr>
<td>14</td>
<td>7.5</td>
<td>6.8</td>
<td>&lt;25%</td>
<td>&lt;75</td>
</tr>
</tbody>
</table>

Table 2 Results of bacterial culture at start and termination of the study

<table>
<thead>
<tr>
<th>Bacterial cultures</th>
<th>At inclusion (n = 17)</th>
<th>At termination (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S. aureus</td>
<td>7 (41%)</td>
<td>6 (54%)</td>
</tr>
<tr>
<td>S. pyogenes</td>
<td>1 (6%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Haemolytic streptococci (non-group A)</td>
<td>3 (18%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Enterobacteriaceae</td>
<td>7 (41%)</td>
<td>5 (41%)</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa</td>
<td>3 (18%)</td>
<td>3 (27%)</td>
</tr>
</tbody>
</table>
minor part and ulcers caused by infectious disease or sickle-cell anaemia may be more important. It is important to treat the cause of ulceration; if the underlying causes are not treated then even the best dressings are not effective.15

Because of financial problems hydrocolloid dressings are often not used in many developing countries. However, economic analyses show that the financial aspect of these dressings compared with classic dressings, such as cotton gauze, may be in favour of hydrocolloid dressings.16,17 Although the costs of hydrocolloid dressings are much higher than other dressings, hydrocolloid dressings can be changed every 2–5 days, sometimes even once a week. In this study, dressings were changed twice weekly because of hygienic considerations; in this hot and humid climate compressive dressings become easily wet and dirty.

This pilot study clearly shows that hydrocolloids are very well tolerated by patients in a tropical climate. There were no problems with the adhering capacity of the hydrocolloid used. All ulcers showed a very good healing tendency and apart from maceration in three patients no adverse events were noticed. It is important to note that during this study compression therapy was given, this may explain the quick wound closure seen with some patients.

In this study no infections were noted, which is consistent with the use of hydrocolloid dressings in moderate climates.11 The microorganisms found are not much different from those found in studies performed in the Western world.18–20 Pathogenic microorganisms were not found more often, and the presence of bacteria do not appear to have interfered with wound healing.

The high rate of bacterial strains resistant to tetracycline and gentamicin may be explained by the extensive use of these antibiotics in ointments for wound care in Suriname. The use of antibiotic containing ointments is not recommended because of the possible development of bacterial resistance and the risk of causing contact allergic reactions.21,22 Moreover, in most chronic wounds use of antibiotics appears to be unnecessary.23

Conclusions

This study indicates that hydrocolloid dressings may function well in the extreme humid conditions of a tropical climate. No infections were noted in the group studied. This study revealed no differences in the frequency of bacterial infection or colonization of the wound from those recorded in studies performed in temperate regions.

Acknowledgements

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References

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