



<p>‣ Quote of the month</p> <p style="text-align: right;"><b>Page 2</b></p>	<p style="text-align: center;">—<b>Editorial</b>—</p> <p>The post summer (don't say autumn, I am not willing to accept the change of season yet!) conference season got under way with a full house on 6th Sept at the 8th Scottish Wounds UK event in the Glasgow Thistle Hotel. Delegates were able to hear about wound debridement and cleaning, granulation and closure of wounds, the diabetic foot, surgical and trauma wounds, pressure ulcers and lower limb management. All presentations were supported by case reports to bring the sessions alive. In a parallel event in the hotel, Wounds UK and ConvaTec launched the Care Home Support System (CHSS) to over 100 Care Home professionals, of whom more than half were Managers. Joyce O'Hare, Tissue Viability Advisor for the Care Commission in Scotland, gave an overview of the regulation and inspection scene and clearly showed the need to ensure all aspects of tissue viability care are taken care of in the care home setting. The CHSS package, a new way of providing tissue viability service to the independent sector, was then described to the audience and shown how it would help to meet Care Home teams' needs and responsibilities. A full room and lively post-programme discussions demonstrated the need for tissue viability support in this sector.</p> <p>In Walsall on the 19th and 20th Sept the Lindsay Leg Club Foundation ran a highly successful and entertaining dinner and fund raising evening and one day conference entitled Expanding Our Horizons: leg care in the 21st Century. Sessions, both spoken and workshop style, looked at exudate management, chronic oedema and lymphoedema, infection control, vascular pathways, compression therapy</p>	<p>‣ Product News</p> <p style="text-align: right;"><b>Page 3</b></p>
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	<p>and dressings. As well as these events the European Pressure Ulcer Advisory Panel, European Tissue Repair Society, the Wound Management Association of Ireland meetings will have taken place but you can still look forward to your annual educational top up at Wounds UK at Harrogate 2007 12 - 14th November. So crack on and fill in that form that's been on your desk waiting for a quiet 5 minutes, you wouldn't want to miss out!</p>	
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➤ **Quote of the month**

*'Working within the NHS is a covenant, something precious welded to professionalism and excellence; many are bound to it by means of ideology and belief: it is for them an article of faith'* - heady stuff yet it somehow speaks volumes as to why NHS workers keep going in spite of all the day to day difficulties. Perhaps not surprisingly the quote can be found in an article on a survey on NPfIT (Harwood J [2007] NPfIT branded expensive and unsuccessful. Health Director. 5: 2 (July); 26 - 27).

➤ **Journal peripherique**

An occasional series of interesting articles from journals you might not normally read. This month a little something on skin complaints and diabetes from Diabetes Care - Pavlovic M et al (2007) The Prevalence of Cutaneous Manifestations in Young Patients With Type 1 Diabetes. Diabetes Care 2007; 30: 1964-7.

The study aimed to assess the prevalence of skin disorders in children and adolescents with type 1 diabetes. 212 patients with diabetes and 196 matched controls were examined. 142 (68%) had at least one skin disorder, compared with 52 (26.5%) of controls. Diabetes-associated lesions were found in 81 (38%). Acquired ichthyosis, rubeosis faciei, diabetic hand, and necrobiosis lipoidica were seen in 22 vs. 3%, 7.1 vs. 0%, 2.3 vs. 0%, and 2.3 vs. 0% of

type 1 diabetic and control subjects, respectively. The prevalence of fungal infections in patients and control subjects was 4.7% and 1.5%, respectively. Xerosis was found in 22% but only 3% of controls. Cutaneous manifestations are common in patients with type 1 diabetes, some developing early on in the course of the disease which the authors conclude justifies the early inclusion of a dermatologist in their management.

#### ‣ **Charity for wounded soldiers**

A new charity was launched on Monday 1st October called 'Help for Heroes', set up to help provide facilities and assistance for British Servicemen wounded in the current conflicts of Afghanistan and Iraq. The Charity takes no position on any conflict. It simply aims to provide much needed support for members of the armed forces who have been wounded and require considerable rehabilitation help.

There was a trailer piece in the Daily Telegraph on 27th September by Boris Johnson and it was also covered by The Times on September 30th([www.timesonline.co.uk/tol/news/uk/article2558222.ece](http://www.timesonline.co.uk/tol/news/uk/article2558222.ece)). If you would like to get involved, make a contribution or find out more contact Hadyn Parry [hadynparry@tiscali.co.uk](mailto:hadynparry@tiscali.co.uk)

#### ‣ **Lymphoedema Patient Survey**

The British Lymphology Society and Lymphoedema Support Network are conducting an audit of the treatment of skin infections in people with lymphoedema. It is a survey for patients to complete, so download and copy the form from the link and get encouraging!

[http://www.thebls.com/alert.php?alert\\_id=2](http://www.thebls.com/alert.php?alert_id=2)

#### ‣ **Product News**

##### ***Boxes of gloves on prescription***

A new latex-free examination glove has been approved on prescription. Made of a unique synthetic formulation, Vitrex gloves are free of latex, powder,

chemical accelerators and protein. Conforming to EN455, Vitrex are an ideal low risk solution for wound-care in the community

Vitrex non-sterile gloves are available in small, medium and large, presented in boxes of 25 pairs. For more information contact Richardson Healthcare on 08700 111126.

### ***Telemedicine revolution rolls on***

With the likely increase in the prevalence of leg ulcers, wounds and their associated management costs, it is even more important for nurses to be able measure and predict outcomes. Leg Ulcer Telemedicine (LUTM) is a dedicated, secure, asynchronous, shared electronic record system specifically designed to create a fast and effective communication link for community nurses and community or hospital-based leg ulcer and chronic wound clinics, It can also be used personally by a TVN or a nurse involved in research or clinical trials. It allows for the incorporation of colour digital images into a shared electronic record. The software includes ulcer size measurement, time to healing prediction and automatically plots actual ulcer healing as a graph that can be printed and exported.

A FREE 3 month trail is now available. For more information please see the website [www.CooperMedical.co.uk](http://www.CooperMedical.co.uk) or email [robin@coopermedical.co.uk](mailto:robin@coopermedical.co.uk)

### **➤ WWW - Wonderful Website World**

#### ***Community Services Efficiency Delivery***

Snappy nom n'est ce pas - non! Well despite the naff nomenclature you might care to check out this site from the Care Services Improvement Partnership ([www.csed.csip.org.uk](http://www.csed.csip.org.uk)) who apparently 'work collaboratively with all councils throughout England supporting them to achieve sustainable efficiency improvements in adult social care' - have a look at 'Transforming Community Equipment and Wheelchair Services' and for the big picture thing 'Community Equipment: A vision for the future' but I would suggest you look at the 'Summary of Outline Model' first, here is a radical but interesting little taster: -

*'What is the model?*

The model is a retail solution and proposes that state bodies issue users and carers where there is an assessed need with a 'prescription' that can be exchanged for free equipment at an approved/accredited retailer.

The model also proposes encouraging the development of new Independent Needs Assessors who can assess an individual to determine not only what equipment may help, but who can also provide other skills e.g. additional therapeutic intervention or other supportive services and advice.

*What will the 'prescription' entitle users to?*

The 'prescription' will enable users and their carers to obtain the equipment that they are currently entitled to receive and they will not have to pay for that equipment.

It is proposed that users and their carers will receive equipment from a national catalogue - a catalogue with details of nationally agreed products and prices. If they would prefer equipment not on the national catalogue, they can 'top up' the 'prescription'. This means that the 'prescription' could form the state contribution to the cost of purchasing the equipment the individual feels they would prefer to have.'

### ***Mining for Gold***

Well not gold perhaps, but information nuggets at The Information Centre for Health and Social Care <http://www.ic.nhs.uk>

See 'Prescriptions Dispensed in the Community Statistics for 1996 to 2006: England' Table 9 Number, net ingredient cost (NIC) and average NIC per prescription item by British National Formulary chapters, 2005 and 2006 - <http://www.ic.nhs.uk/webfiles/publications/PrescDispensed%2096to06/Bulletin%20220807%20version%20for%202006.pdf>

In England the number of dressings and appliance prescriptions went up 10.6% between 2005 - 2006, from 19.6 - 21.7 million prescriptions. The net ingredient cost (This is the basic price of a drug, i.e. the price listed in the national Drug Tariff or in standard price lists. It standardises cost throughout prescribing nationally, and allows comparisons of data from different sources) rose 8.4% from £436 - 472.8 million, although on a per prescription basis the

net ingredient cost fell by 1.9%. So more less expensive prescriptions then; good or bad, debate the issues on your exam paper!

## ➤ Statistics to go

### ***Confidence intervals and relative risk***

Recently I was interested in the paper by Palfreyman, Nelson, and Michael (2007) in the BMJ and their systematic review and meta-analysis on dressings for venous leg ulcers. Their objective was to review the effectiveness evidence for dressings used on venous leg ulcers (VLU) to see if any dressing could be established to be better than another in terms of healing and therefore cost effectiveness. They identified 42 studies that met their inclusion criteria and hydrocolloids were the only dressings featured in comparison trials.

The authors found no evidence that a *'particular class of dressing healed more ulcers....Insufficient data were available to allow conclusions to be drawn about the relative cost effectiveness of dressings.'* Perhaps controversially they concluded *'Decisions on which dressing to apply should be based on the local costs of dressings and the preferences of the practitioner or patient.'* This conclusion on the face of it could be used as evidence by NHS pharmaceutical advisors in their drive to cut costs by inferring that gauze be used directly on the wound because it is cheap, but then TVNs know that causes pain on removal and would be unethical. Valuable though this meta-analysis is in answering the question the authors set themselves, it does not of course explore the many patient focussed and symptom controlling outcomes on which dressing choice decisions are made in clinical practice. Neither did it specifically address the hard to heal group on which dressing choice may impact significantly in turning around chronicity and as such impact on cost effectiveness in this sub group of VLU patients. However, setting that discussion aside, the authors used confidence intervals to support their conclusion that *'Hydrocolloids were no more effective than simple low adherent dressings beneath compression (eight trials; relative risk for healing with hydrocolloid 1.0; 95% confidence interval 0.83 to 1.28).'*

First then relative risk (RR) (also known as relative ratio) shows how many times more or less the individuals with the risk factor are likely to get the

disease relative to those who do not have the risk factor (Dorak 2007), though in this study it was used to describe if the hydrocolloids were more or less likely to produce faster healing than control products. An 'RR' of 5 for example would suggest that the likelihood of faster healing with a hydrocolloid would be 5 times higher than with the standard dressing. The higher above 1.0 the better, so in our example a figure of 1.02 is so low for the hydrocolloid as to be equal in all practical terms to the standard dressing.

Confidence intervals give another view on the 1.02. They show how much store you can put in or confidence you can have that the headline figure is representative of the truth. A 95% confidence interval says that if the experiments were repeated again and again 95% of the data would fall between the range (the range in the paper was 0.83 -1.28) and would contain the true parameter value (Everitt 2003), which in the study paper was 1.02. The narrower the intervals the better as the parameter value is then closely related to the majority (95%) of the data used to produce it. Confidence intervals assume that random sampling has been used in the study/studies (and this was part of the inclusion criteria for the example study), however, clinical judgment is necessary to supplement statistical analysis on non-random sample study conclusions when generalising to individuals not studied (Munro, 2005).

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