

Unlocking the Potential of Ease-of-Use NPWT: Enhancing Healthcare Practices And Optimizing Patient Outcomes

Supported by an educational grant from Solventum, Medical Surgical Business

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Disclosures

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 - This activity has been independently reviewed for balance
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Learning Objectives

- Analyze the science and clinical application of a novel peel and place dressing for negative pressure wound therapy (NPWT), determining which wound types are most appropriate for this technology
- Explore how novel ease-of-use NPWT technology can drive improvements in healthcare practices, enhancing patient support from hospital to home
- Examine case-based scenarios highlighting the components of the NPWT toolkit and demonstrate the step-down therapies involved in progressing toward wound closure

Q&A

Questions are welcomed!

**Submit your questions anytime
via the question box.**

The Science and Clinical Application of a Novel Peel and Place Dressing and the Appropriate Wound Types

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Wound Care Is a Multi-Step Process Including

- Patient and wound assessment
- Initial debridement that removes necrotic and fibrinous tissue and decreases the bacterial load
- Initiation of appropriate cleaning
- Maintenance debridement
- Antimicrobial therapy – When indicated
- Removal of exudates
- Increasing granulation tissue in preparation for wound closure

Why Do Wounds NOT Heal?

Intrinsic patient factors-focal/wound:

Infection, growth factors, scar tissue, necrosis, pressure, etc.

Intrinsic patient factors-systemic/host:

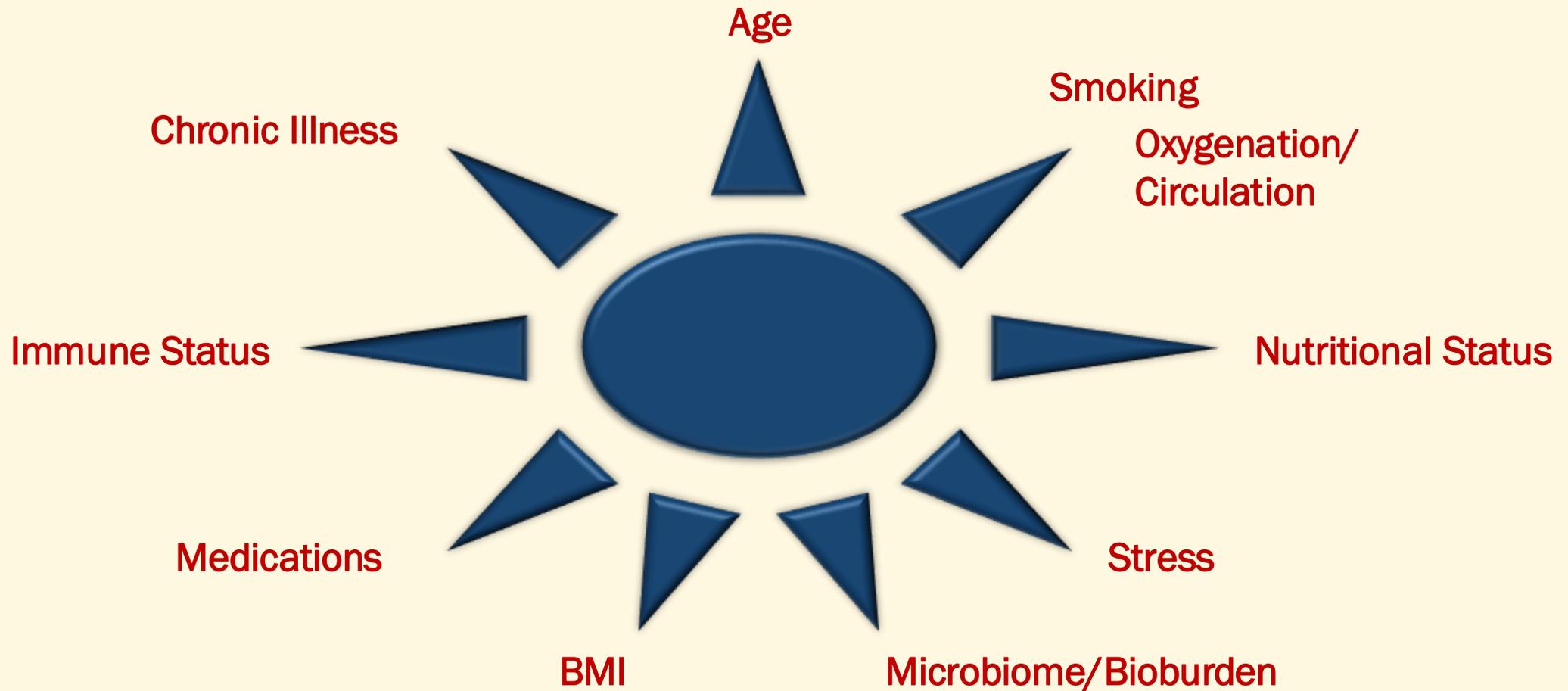
Circulation (PVD) immunity (Diabetes), metabolism, nutrition, etc...

THE BIOLOGICALLY BANKRUPT PATIENT

Extrinsic factors:

Compliance, socioeconomic, etc.

Patient Factors that Impede Healing



Local Wound Environment

Why Do Wounds NOT Heal?

In other words...

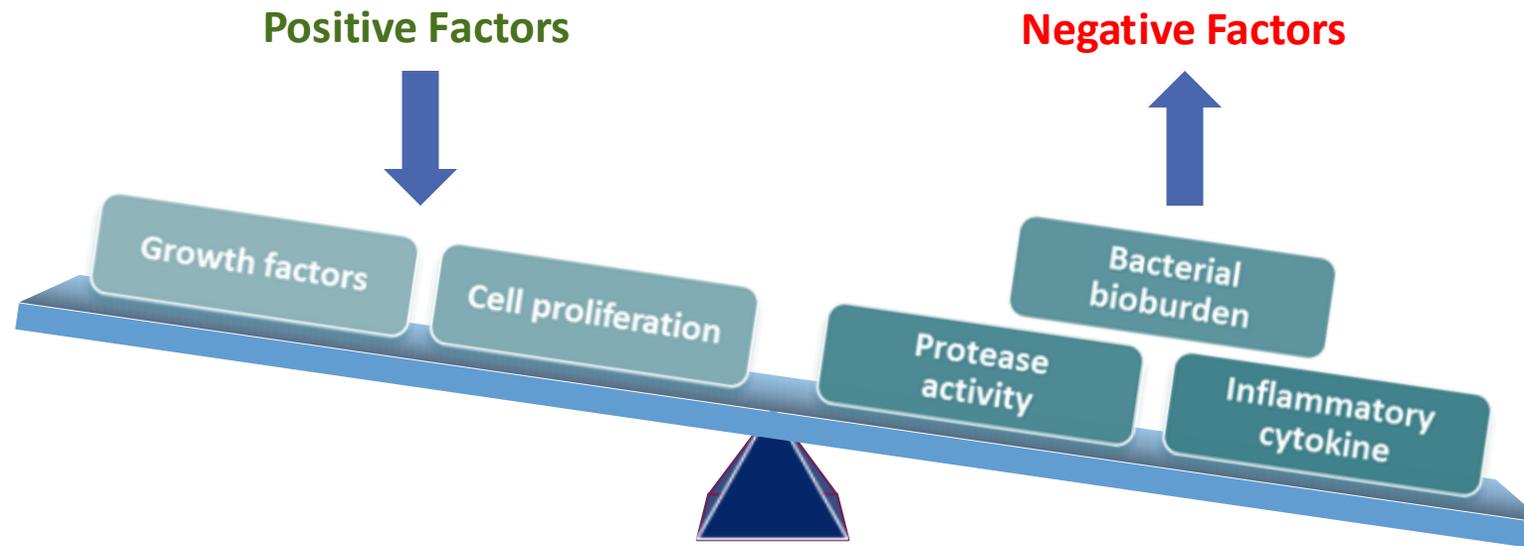
**Something is wrong with the wound,
or something is wrong with the patient**

If neither, look in the mirror...

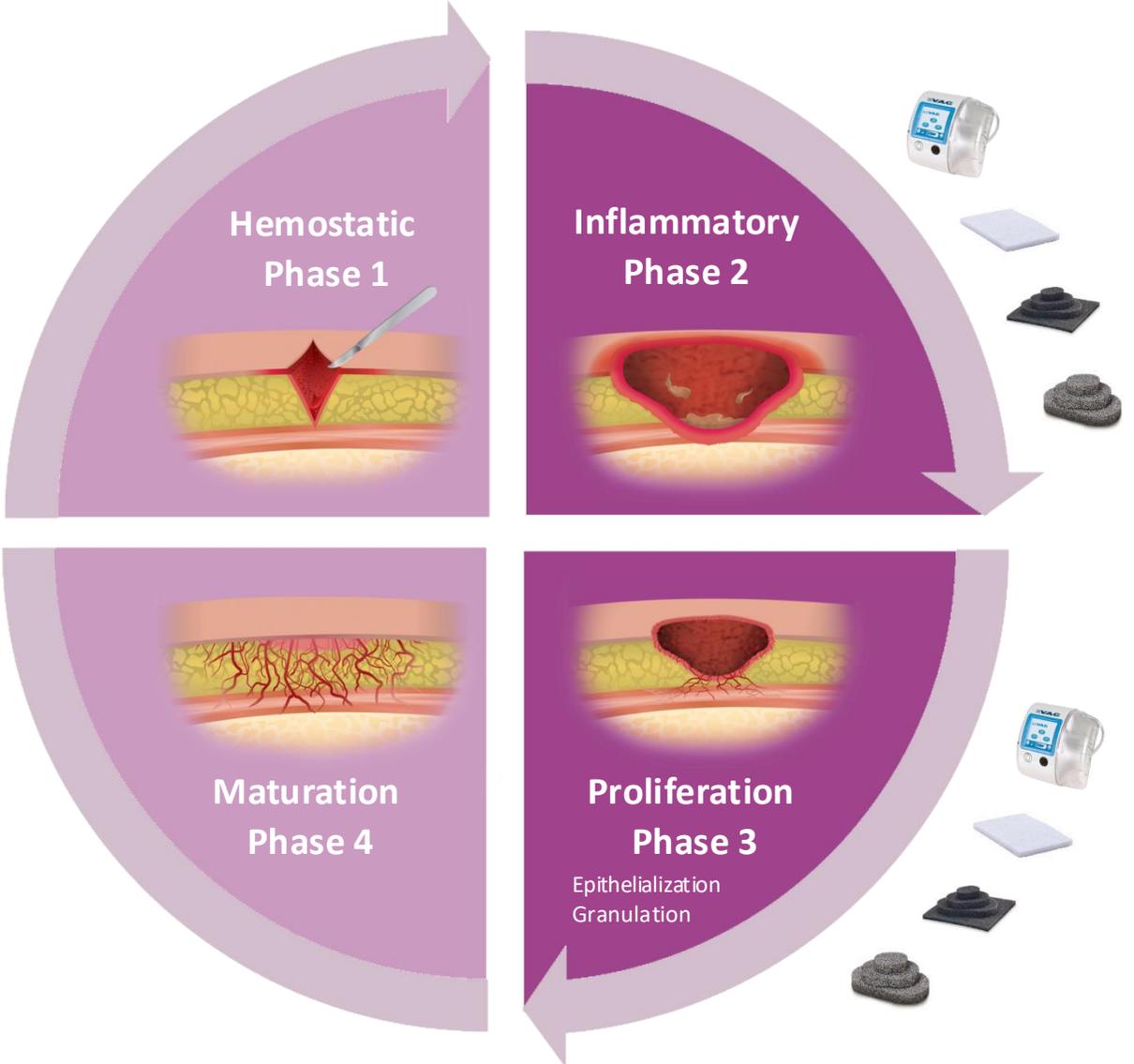


The Inflammatory Environment

Environment	Chronic Wound	Healing Wound
ECM	Damaged	Functional
Inflammatory cytokines	High	Low
Protease activity	Increased / excessive	Low / in balance
Reactive oxygen species	Increased	Low
Cell competence	Senescent	Competent (mitotically)
Metabolic activity	Low	High



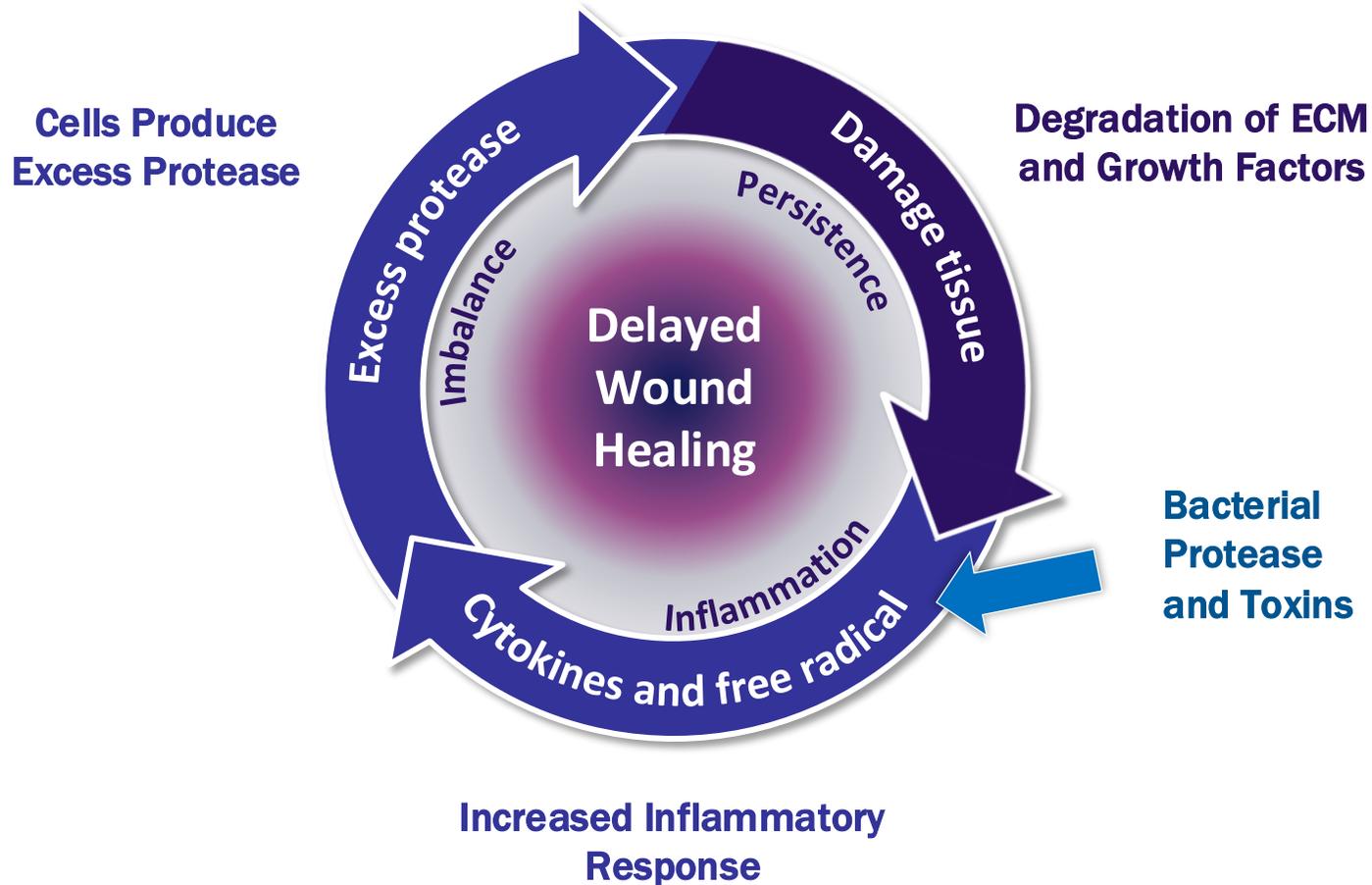
When to Use VAC Therapy



*not covered under all payor agreements

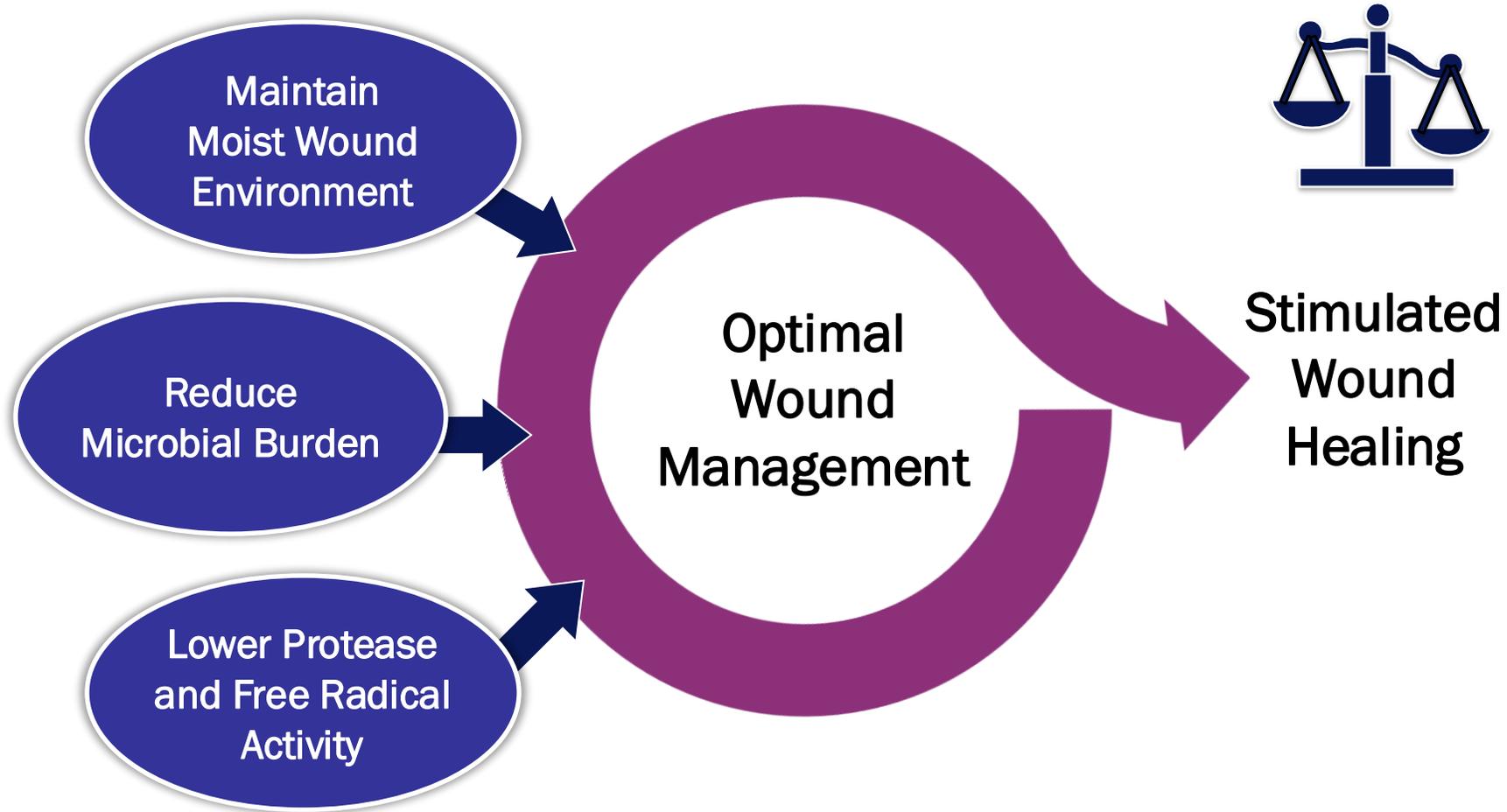
To Kick Start Healing, We Must Break the Cycle....

IMBALANCE Causes Delayed Healing!



Rebalance the Wound Environment for Optimal Healing

REBALANCE for optimal wound management



VAC Therapy Through the Years



1995

2002

2005

2006

2016



Clinical field trials in
Operation Desert Storm



Hurricane Katrina

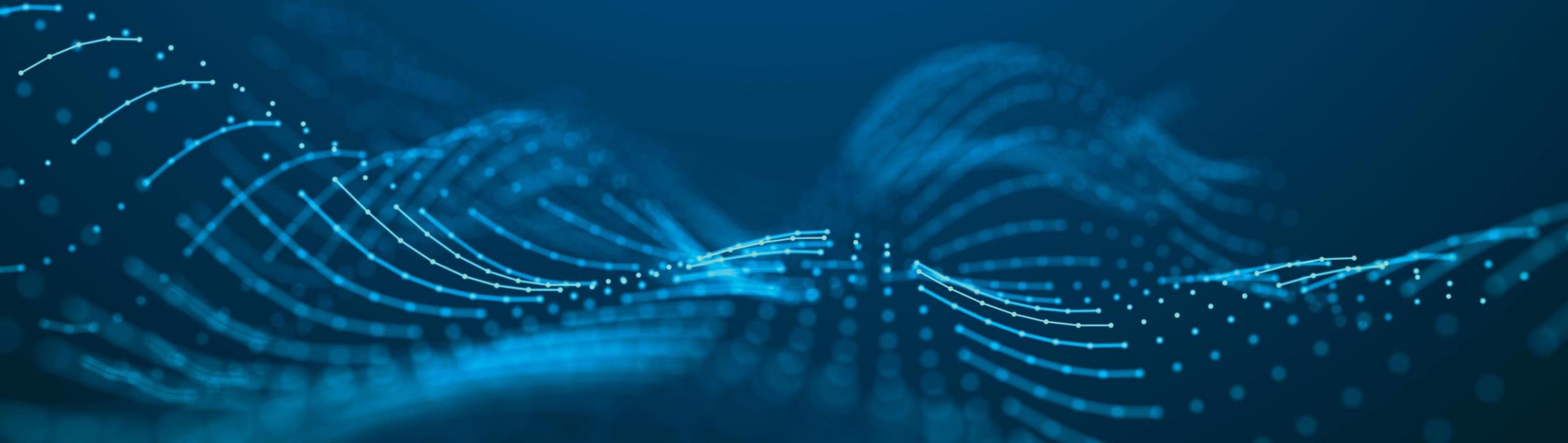


What's Next



Peyton Manning leads the
Broncos to victory in Super
Bowl 50, then retires

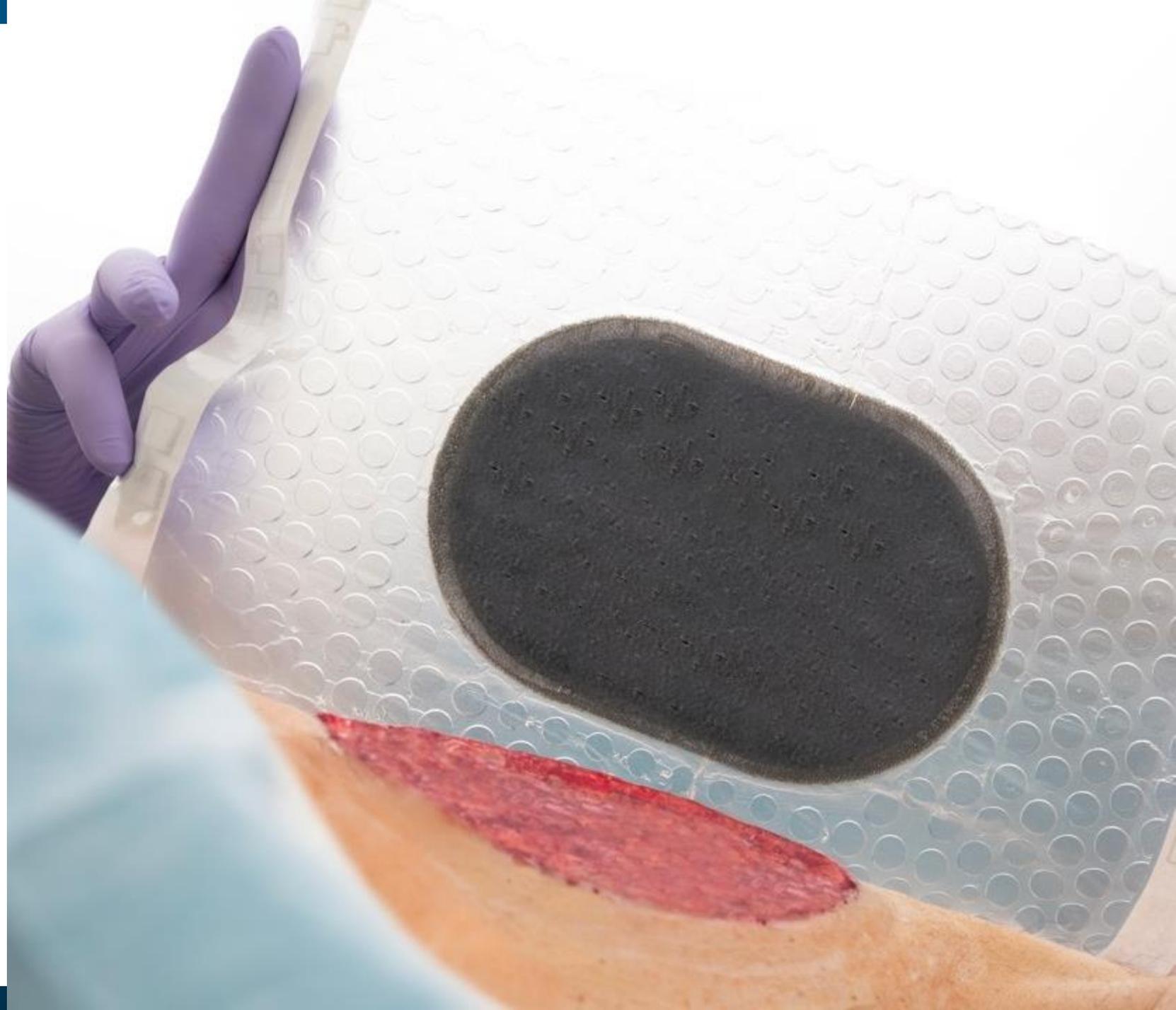
Peel and Place Dressing



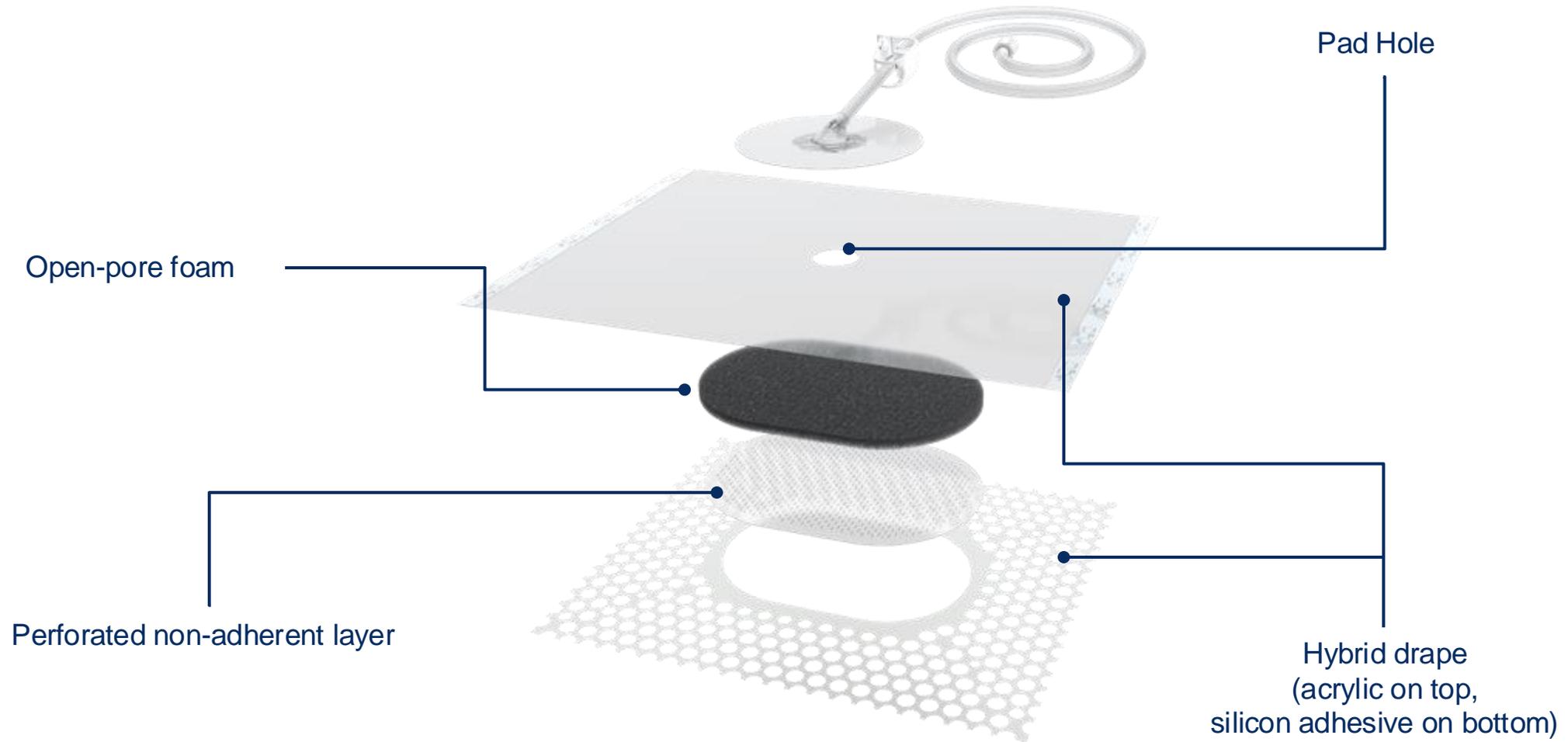
The first VAC dressing with up to 7-day wear time

Available to

- **More patients**
- **More care settings**



All-in-One Design



The bottom of the dressing

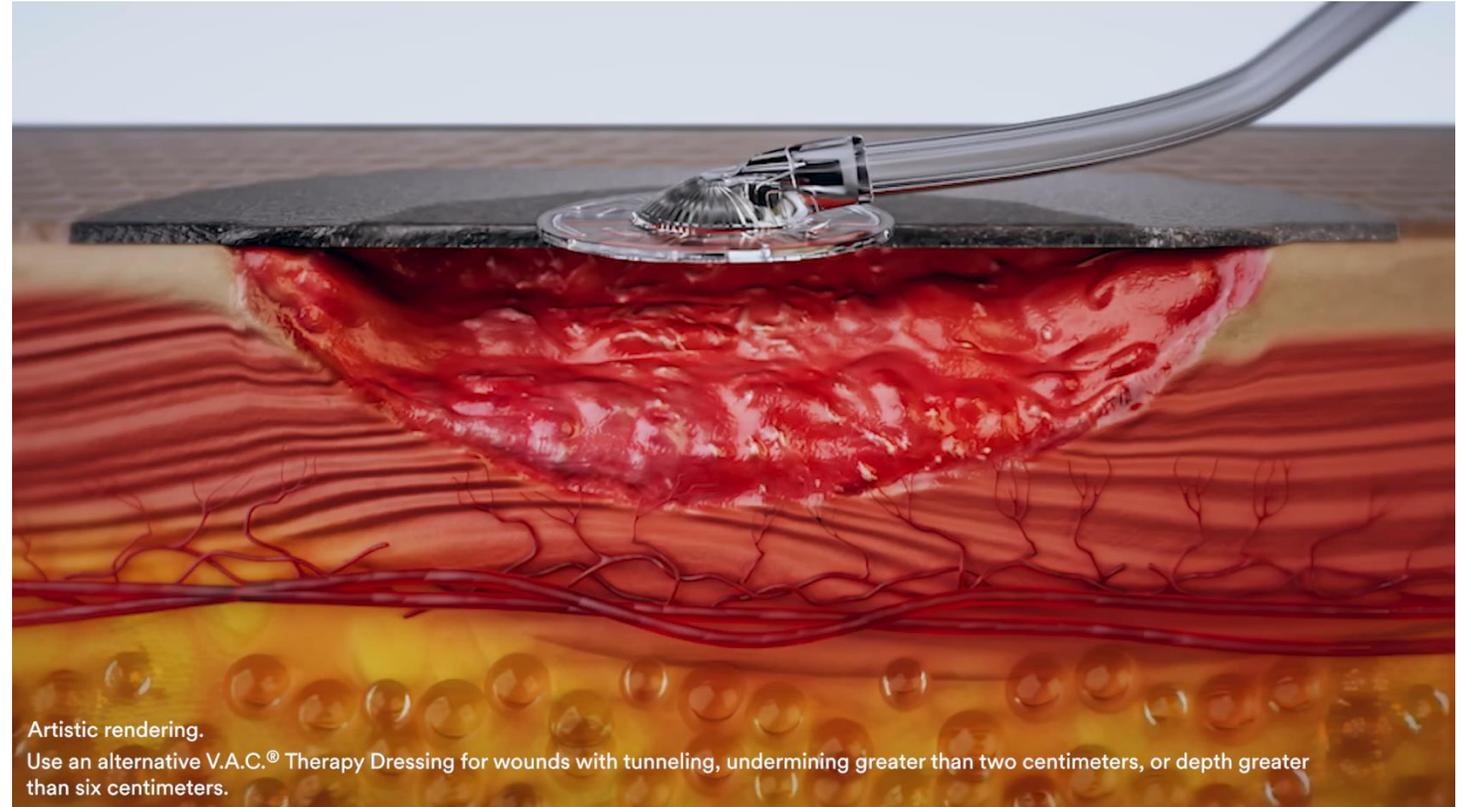
Perforated, non-adherent bottom layer allows up to 7 days of wear by mitigating tissue ingrowth and reducing foam adhesion to the wound and pain upon removal



Mechanism of Action (MOA) Overview

When used in conjunction with NPWT unit, peel and place dressing promotes wound healing by:

- Removing exudate and infectious materials
- Reducing edema
- Promoting granulation tissue formation and perfusion
- Preparing the wound for closure



Artistic rendering.

Use an alternative V.A.C.® Therapy Dressing for wounds with tunneling, undermining greater than two centimeters, or depth greater than six centimeters.

MOA: Macrostrain

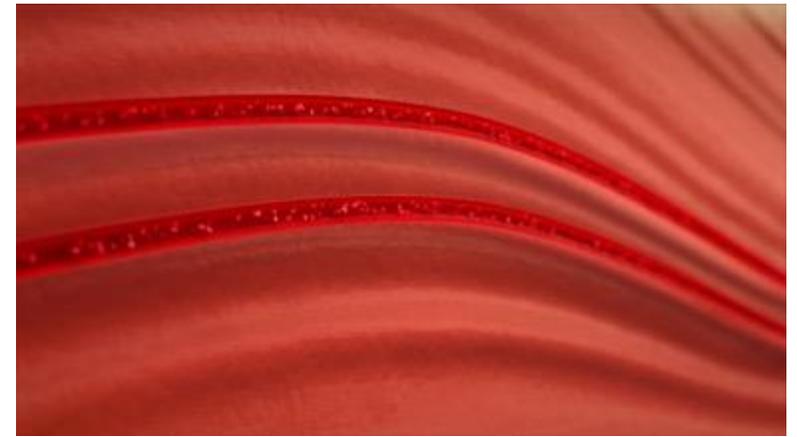
Facilitates removal of exudate and infectious material



Facilitates blood flow into the wound bed, which provides oxygen



Enables perfusion to the wound bed



Macrostrain facilitates removal of exudate that may inhibit wound healing and assists in reduction of edema, facilitating blood flow into the wound bed by providing oxygen and nutrients for healing.

MOA: Microstrain

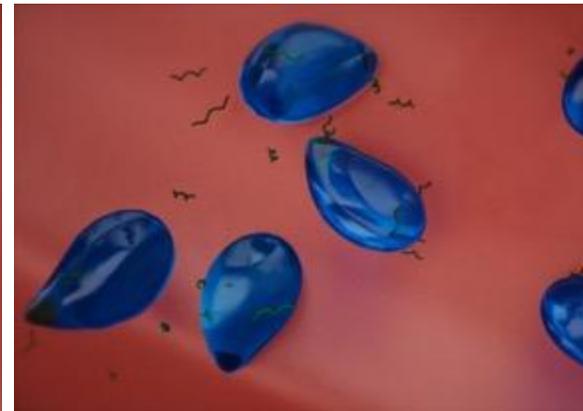
Deep tissue
micro-deformation



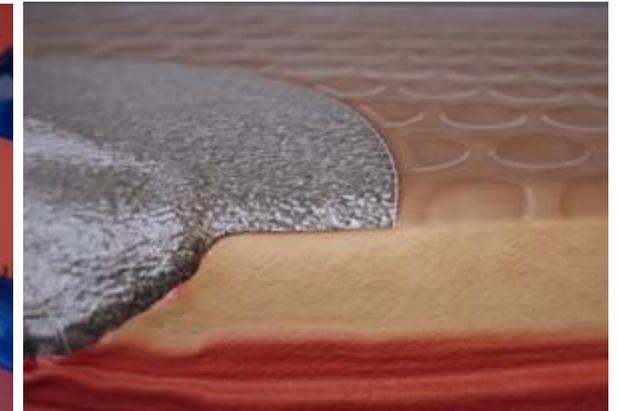
Stimulates
cellular activity



Increase biomarkers
indicative of
pro-wound healing



Mechanical forces extend
beyond the wound bed



Finite element analysis suggests that peel and place dressing induces microstrain at the wound bed surface, but also more deeply in the underlying and surrounding soft tissue.

Pre-clinical studies demonstrated increased key biomarkers indicative of pro-wound healing*

MOA

Macrostrain

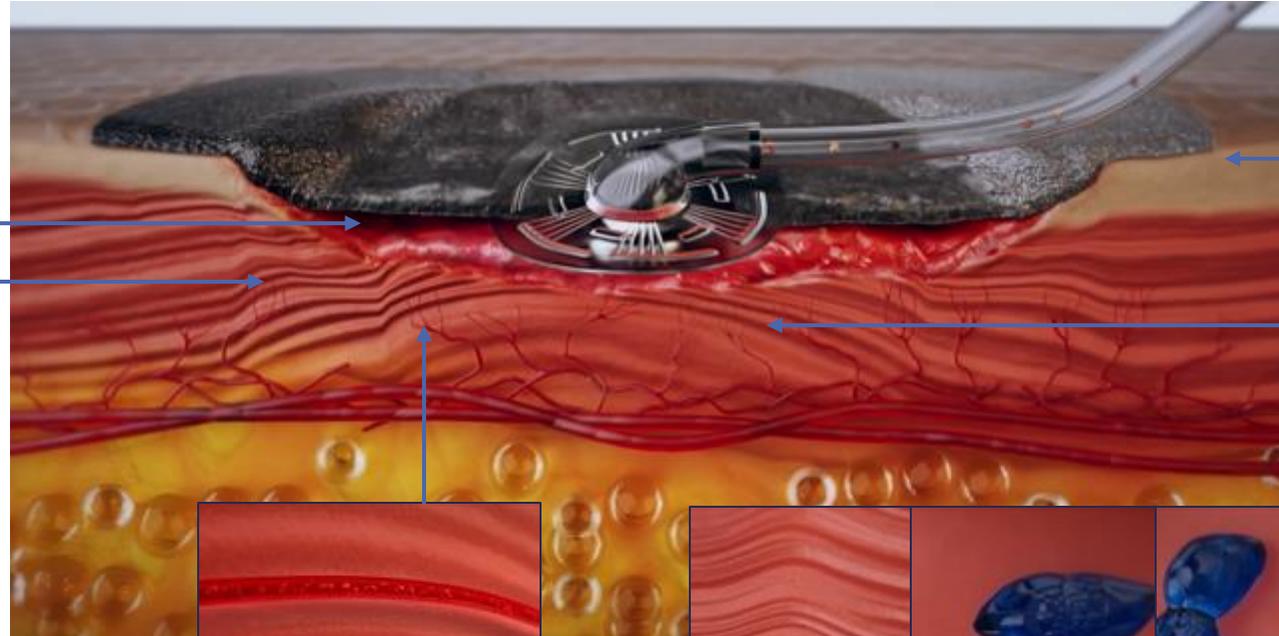
Microstrain



Removes exudate and infectious material



Reduces edema



Mechanical forces extend beyond the wound bed



Promotes perfusion



Deep-tissue micro-deformation

Stimulates cellular activity

Increase biomarkers indicative of pro-wound healing

Wound Types that Benefit from Peel and Place Dressing

Chronic



Acute



Traumatic



Subacute/Dehisced



Partial-thickness Burns



Diabetic Ulcers



Pressure Ulcers



Venous Ulcers



Flaps

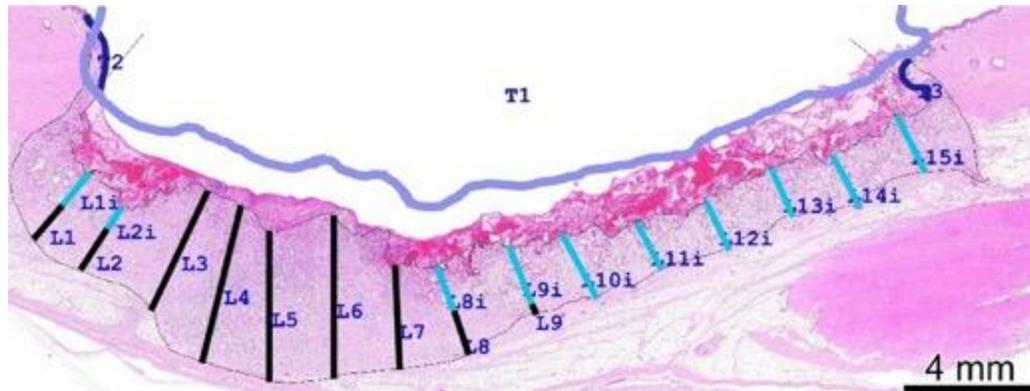


Grafts



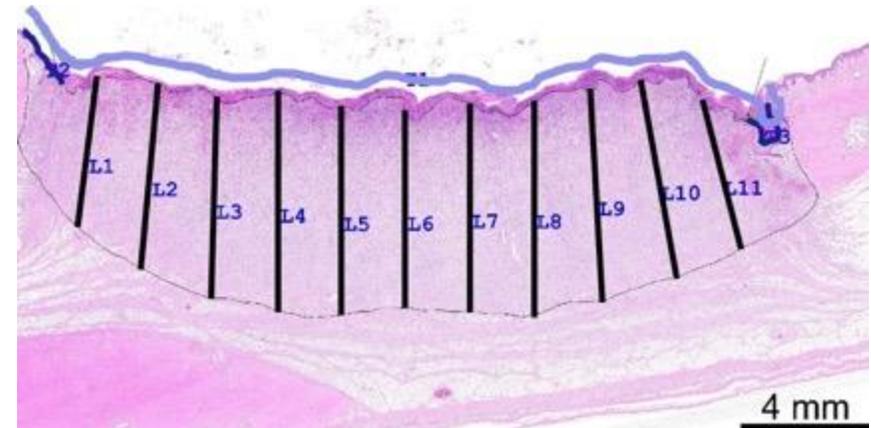
Clinical Benefits Compared to Traditional Foam Dressing

33% greater wound volume reduction*¹



Percent wound volume fill (mean \pm SEM), n=at least 9

2.4 greater granulation tissue thickness*¹

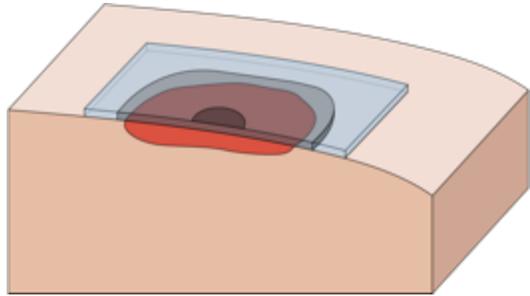


Mean granulation tissue thickness (mean \pm SEM), n=10 or 11

Where Peel and Place Dressing May Be Appropriate

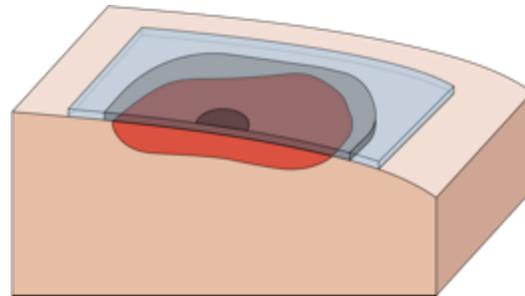
3 sizes to cover a variety of wound depths

Small



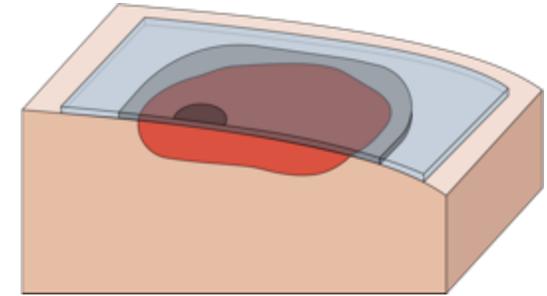
- **Foam:** 6.1cm x 8.6cm
- **Overall Dressing:** 16.9cm x 20.6cm
- **Max Wound Depth:** 2cm

Medium



- **Foam:** 11.1cm x 16.6cm
- **Overall Dressing:** 23.7cm x 29.2cm
- **Max Wound Depth:** 4cm

Large

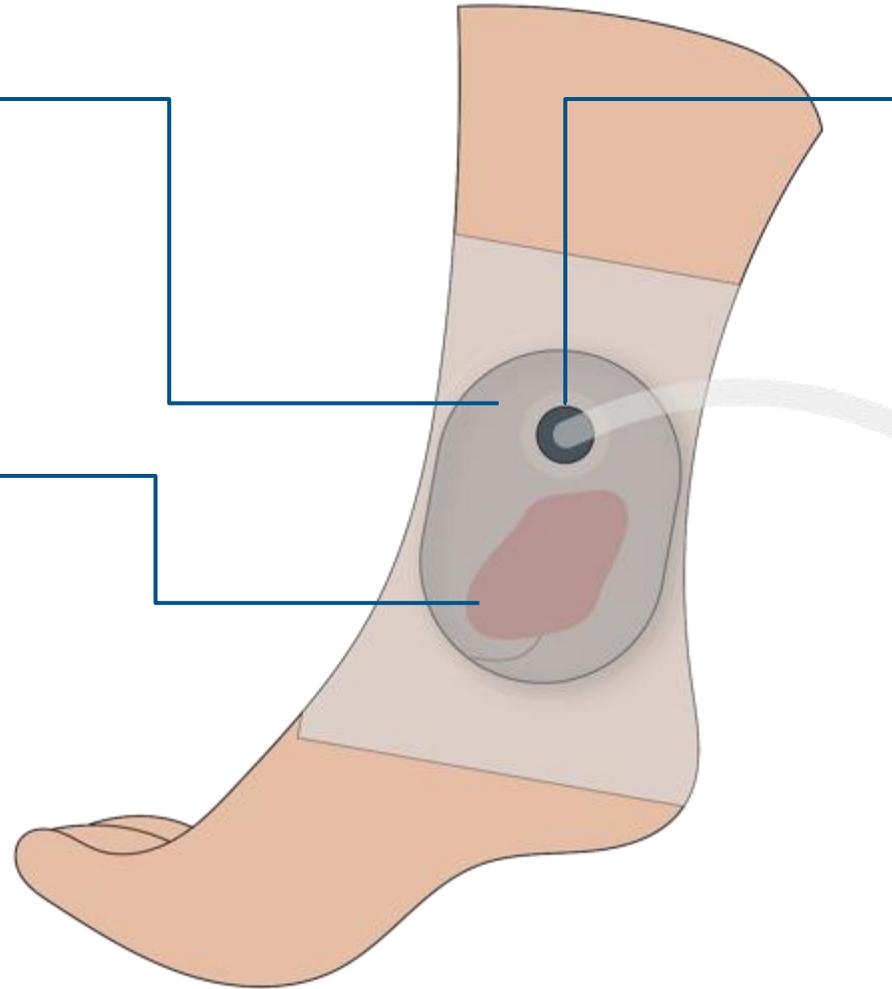


- **Foam:** 13.6cm x 24.2cm
- **Overall Dressing:** 26cm x 35.6cm
- **Max Wound Depth:** 6cm

Considerations

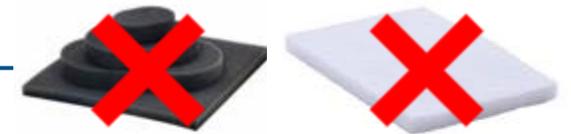
1. Foam should extend beyond wound and touch periwound skin.

3. Undermining must be ≤ 2 cm; no tunneling can be present



2. To offload, select the Large dressing size

4. Don't mix with other dressings. The use of additional foam fillers is prohibited.



Application Tips

⊖ No longer need to

- Cut foam to fit wound
- Count and document number of foam pieces
- Pre-drape or windowpane to protect intact skin
- Cut holes

⊗ Do NOT

- Use skin barriers/protectants as this may reduce adhesive properties
- Use with other NPWT dressing kits or foams, as they have a shorter wear time
- Push foam portion of the dressing down. Allow the dressing to draw down and conform to the wound bed as negative pressure is applied
- Stretch dressing

ⓘ Drape tips

- Apply loosely over the wound area
- Leave at least 5cm border of drape whenever possible
- For curved anatomy, slits may be cut in the drape portion of the dressing to help reduce overlap, drape folds, or remove wrinkles

- **The dressing can stay in place when switching between approved NPWT units**
- **Never leave an NPWT dressing in place for more than 2hrs without active NPWT**

Proteinaceous Materials in the Wound Bed

- Upon dressing removal, the wound bed may show some proteinaceous or fibrinous materials. Cleanse the wound according to your facility protocol or clinical order
- In the pre-clinical porcine and Customer Preference Evaluation, the proteinaceous or fibrinous material was not removed. This material was observed to reduce over time with subsequent dressing changes



**By design and IFU, we know that this dressing
is not for every wound. BUT...**



We have found it beneficial to consider this dressing for every patient as their wound(s) move through the healing continuum based on trajectory and disposition.



We have also found it occasionally beneficial to step down in dressing size incrementally, or less commonly, step up in size based on trajectory and disposition.



Best Practice: Survey Response Results

- Go for the easy wounds first, where you know application will be simple and the dressing will perform well
- Remember: Wound appearance will be different than with other NPWT dressings
- When in doubt, size up!
- Pay attention to the minimum and maximum wound sizes and depths for each dressing
- Be mindful of narrow and deep wounds; ensure dressing can conform adequately
- Blockage alarms may be noticed due to thinner foam or active bleeding
- Is it maceration, or is it wetness? Consider options for protecting periwound skin, especially if the wound is progressing well. Keep therapy on!
- Adjust the pressure settings up (-150 mm Hg max) if seeing too much fluid in the dressing

Additional Insights

- To date, our region has taken care of several patients with peel and place, utilizing all dressing sizes. *Bravo Central Ohio-based team! Thank you!*
- Less effort than anticipated required for seal creation
- Patient self-guided “drape repairs” were easily executed
- Trimming and shaping of drape was helpful with challenging anatomy and in avoiding circumferential drape application
- For plantar foot wounds, the large dressing with offset aperture allows for *pseudo bridge*
- If necessary, plantar foot wound trac pad placement is feasible
- Low threshold to increase pressure to -150 mm Hg based on wound disposition and periwound appearance

Additional Insights

- “Transient dermal deformation” (TDD) at track pad site was seen on occasion, but with more frequency at -150 mm Hg; in our experience, these changes persisted for several days, but largely resolved (**can lessen effect by changing orientation of track pad placement at subsequent re-applications*)
- **Marked decrease** in periwound swelling was evident
- In patients who transitioned from “standard VAC” construct to peel and place, marked pain decrease was noted
- Notable canister volume decrease without concomitant dressing saturation was seen compared to traditional VAC construct (*local lymphatic periwound recruitment or some other mechanism*)
- Although hard to quantify fully at this time, healing trajectory seems slightly more robust with peel and place compared to traditional VAC construct (***decreased total time of therapy, wound volume decrease, etc.***)

Most Ideal Wounds for Initial Dressing Placements



Grafts

Why:

Time savings, including reduced OR time, fewer supplies needed

Dehisced Surgical Wounds

Why:

If only part of the wound is dehisced, can easily cover and treat the whole incision

Less complex wounds

Why:

Help ensure success, not your train wrecks or super complicated placements

Multiple wounds

Why:

Even greater efficiency – dressing can be placed over intact skin between wounds

Wound clinic patients who can't get home health

Why:

Patients can follow up in WCC weekly

Irregular shapes

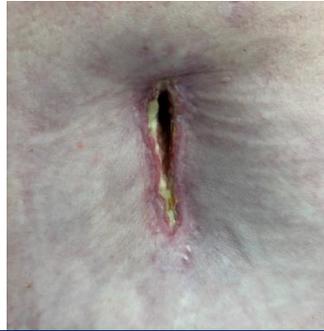
Why: Can be placed over intact skin; no need to cut, big time savings

Less than Ideal for Initial Dressing Placement



High exudate in dependent position

Why: Exudate sometimes pools and may cause maceration on the skin



Skinny and deep

Why:

Dressing is unable to conform to the bottom of the wound bed and can result in exudate pooling



Active bleeding or lack of homeostasis

Why:

All VAC dressings require hemostasis to be achieved; and may cause blockage



DFU with inadequate offloading

Why:

Exudate squeezed out of the tissue may over-wet or macerate periwound skin (eg, bedrest, scooters, etc)



PI with inadequate offloading

Why:

Source of the injury is not addressed, so wound is not likely to progress (eg, turning, positioning, padding, etc)



Wounds receiving compression

Why: Not indicated together; compression may lead to reduced exudate removal and maceration or a pressure point

Setting the Right Expectations

- The new goal is wound fill, not color/colour
- Color/colour will be more pink, less red
- There may be some proteinaceous material on the surface
- There may be significant improvement in appearance of periwound tissue
- There may be over-wetting or maceration in periwound tissue
- There may be some temporary tissue distortion under the trac Pad
- There may be more odor/odour at 7 days



Case Examples

Peel and Place Dressing



Case 1: Below-Knee Amputation Dehiscence

- 28y Male presented to a practice partner with a long history of post-traumatic arthritic deformity of the left lower leg and foot
- Had attempts at reconstruction prior to presentation; ultimately, limb was deemed beyond salvage orthopedically, and a below-knee amputation was elected
- Delayed surgical healing occurred and was sent to me for advanced wound care
- Agreed to VAC therapy with peel and place large dressing at -125 mm Hg

Case 1: Initial Presentation



Case 1: Initial Placement



Case 1: Knee Crutch Ambulatory Aid



Case 1: After 1 Wk of Peel and Place



*Pressure increased to -150 mm Hg
in light of increased moisture and
periwound irritation

Case 1: After 2 Wks, Therapy Discontinued



Case 2: Lawnmower Injury of Lower Leg

- 77y Male presented with a lawnmower blade laceration, left medial calf
- Was seen at a local ED, basic care initiated, and referred over for more advanced wound care
- Initial debridement carried out; agreed to NPWT with peel and place
 - Large dressing at -125 mm Hg

Case 2: Initial Presentation



Case 2: Follow-up 1 Wk; Dressing before Take Down



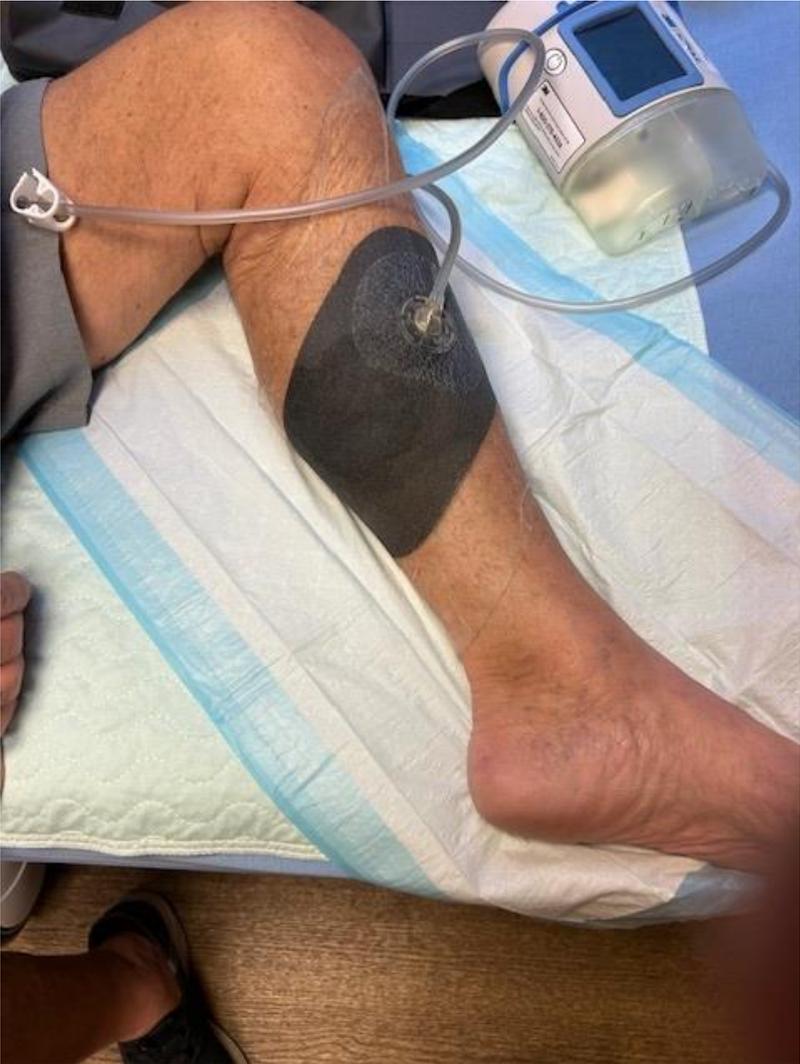
Case 2: Follow-up 1 Wk with NPWT Peel and Place



Case 2: Transient Dermal Deformation (TDD)



Case 2: Follow-Up 2 Wks with NPWT Peel and Place



Case 2: Follow-Up 2 Wks with NPWT Peel and Place



Case 2: Follow-Up 3 Wks with NPWT Peel and Place

VAC therapy
discontinued



Case 3: Diabetic Foot Infection/Surgical Wound

- 65y Male presented with a severe foot infection as a result of a puncture wound and retained foreign body; was found to be diabetic previously undiagnosed with vasculopathy.
- Had initial emergent debridement and foreign body removal at the hands of a practice partner and was referred over for additional specialty wound care
- Was optimized vascularly and underwent debridement with NPWTi-d; was transitioned to traditional VAC with peel and place, large dressing at -150 mm Hg

Case 3: Diabetic Foot Infection/Surgical Wound Intra-Op Photos



Case 3: Diabetic Foot Infection/Surgical Wound Intra-Op Photos



Case 3: Diabetic Foot Infection/Surgical Wound After 1 Wk of NPWTi-d



- After NPWTi-d, patient had a few days of “standard” VAC therapy prior to peel and place



Case 3: Diabetic Foot Infection/Surgical Wound Initial Peel and Place Application



Case 3: Diabetic Foot Infection/Surgical Wound Initial Peel and Place Application



Case 3: Diabetic Foot Infection/Surgical Wound Follow-Up at 1 Wk



Case 3: Diabetic Foot Infection/Surgical Wound Follow-Up at 1 Wk



Case 3: Diabetic Foot Infection/Surgical Wound Follow-Up at 1 Wk



Case 3: Diabetic Foot Infection/Surgical Wound After 2 Wks of Peel and Place



Case 3: Diabetic Foot Infection/Surgical Wound After 3 Wks of Peel and Place



Note persistent
moisture

Case 3: Diabetic Foot Infection/Surgical Wound After Peel and Place VAC “Holiday”



1 wk of ORC, collagen,
and silver-ORC matrix,
changed every other
day

***Although not easily
seen in photo, slight
increase in swelling
noted during VAC
holiday**

Case 3: VAC Peel and Place Resumed Medium Dressing Step Down from Large



Case 3: VAC Peel and Place Resumed Medium Dressing Step Down from Large



Initial Experience with a Novel Negative Pressure Wound Therapy Peel and Place Dressing in Lower Extremity Wounds

Ralph J. Napolitano, Jr., DPM, CWSP, FACFAS

OrthoNeuro, Columbus, OH; Heritage College of Osteopathic Medicine, Ohio University, Athens, OH

Introduction

- The application of negative pressure wound therapy to support healing of lower extremity wounds is well-documented.¹
- A recently available multilayer peel and place dressing (MPPD) incorporates a perforated non-adherent layer, reticulated open cell foam dressing, and a hybrid acrylic and silicone drape, which enable it to be placed over the wound and surrounding intact skin.

Purpose

- In this case series, we report the outcomes of application of NPWT with MPPD* in 4 patients with lower extremity wounds.

Methods

- Deidentified data was collected after obtaining informed patient consent and stored in accordance with federal regulations.
- Patients had injuries to the foot or lower leg and received NPWT with MPPD at -125 mmHg for 10-21 days.
- Dressings were changed every 5-7 days.

Results

- Three male and one female patient, ages 28 to 77 years old, were included in the study.
- Wound etiologies included surgical wounds, a traumatic injury, and a decubitus ulcer.
- After 10-21 days of therapy, the wounds showed notable improvement and there was a significant reduction of periwound edema.
- Patient outcomes are shown in Figures 1-4.

Representative Cases



Figure 1. A 40-year-old female with a history of chronic Achilles tendinopathy of the right foot underwent staged repair including adjunct anchor hardware removal. Primary closure was not possible. A) Initial presentation. B) Application of NPWT with MPPD. C) Appearance at first dressing change. D) Application of NPWT with smaller MPPD. E) Appearance at second dressing change. F) Resolution of wound after discontinuation of NPWT.



Figure 2. A 28-year-old male presented with a long history of posttraumatic arthritic deformity of the lower leg and foot. A below knee amputation was elected after unsuccessful reconstruction. Delayed surgical healing occurred. A) Initial presentation. B) Application of NPWT with large MPPD. C) Appearance at first dressing change. Pressure increased to -150 mmHg. D) Appearance after second dressing change.



Figure 3. A 77-year-old male presented with a lawnmower blade laceration in the left medial calf, and was referred for advanced wound care. The wound underwent initial debridement before NPWT. A) Initial presentation. B) Application of NPWT with large MPPD. C) Appearance at first dressing change. D) Application of NPWT with MPPD. E) Appearance at second dressing change. F) Appearance at third dressing change; therapy goals met and NPWT discontinued.

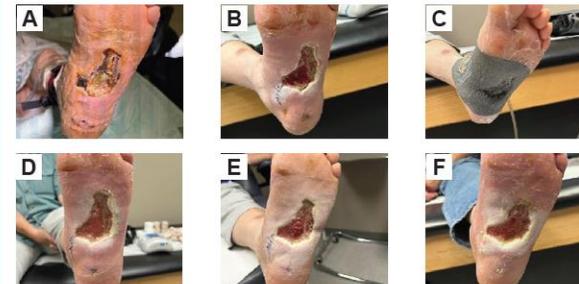


Figure 4. A 65-year-old male presented with a severe foot infection resulting from a puncture wound and retained foreign body. He was found to be diabetic previously undiagnosed with vasculopathy. A) Initial presentation B) Appearance after emergent debridement and foreign body removal, followed by 1 week of NPWT with irrigation and dwelling.¹ C) Application of NPWT with MPPD. Appearances shown at first (D), second (E), and third (F) dressing changes.

Results (cont'd)

- We observed no periwound maceration in 3 patients.
- In the fourth, maceration was noted at the first dressing change and resolved after negative pressure was increased to -150 mmHg.

Discussion

- We have found it beneficial to consider this dressing for every patient as their wound(s) move through the healing continuum based on trajectory and disposition.
- We have also found it occasionally beneficial to step down in dressing size incrementally, or less commonly, step up in size based on trajectory and disposition.
- Trimming and shaping of drape was helpful with challenging anatomy and in avoiding circumferential drape application.
- Pay attention to the minimum and maximum wound sizes and depths for each dressing.

Conclusions

- The new NPWT dressing performed as expected, removing exudate and creating an environment conducive to wound healing.
- Application of the MPPD dressing was quick and easy, requiring only minimal trimming or shaping of the drape.

References

- Capobianco CM, Zgonis T. An overview of negative pressure wound therapy for the lower extremity. *Clin Podiatr Med Surg.* 2009;26(4):619-631.

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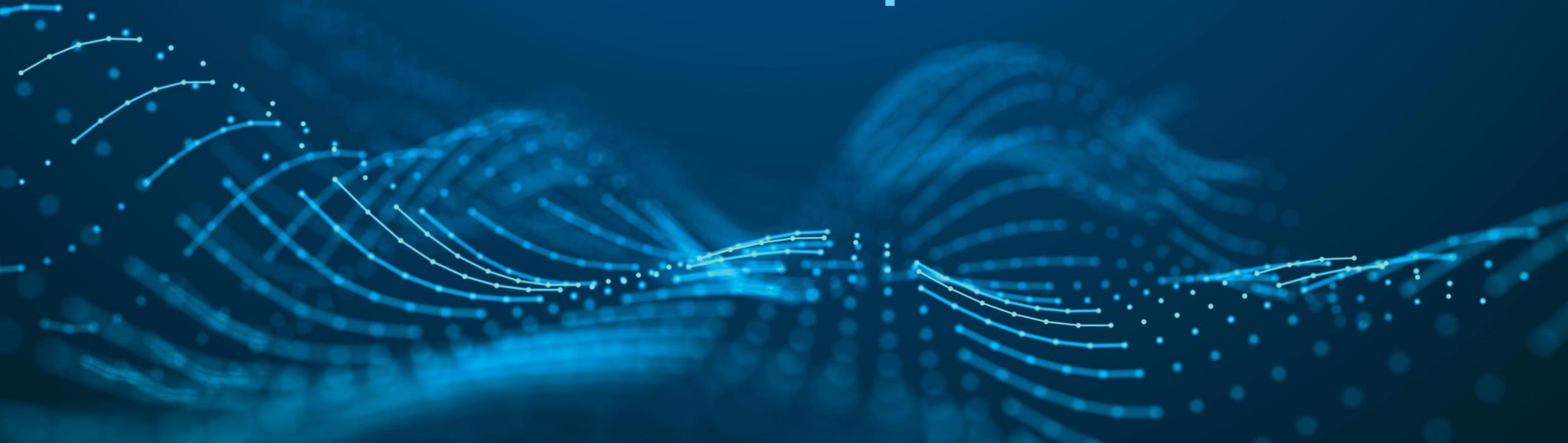
NOTE: Specific indications, contraindications, warnings, precautions and safety information exist for these products and therapies. Please consult a clinician and product instructions for use prior to application. Rx only.

*3M™ V.A.C.® Peel and Place Dressing, †3M™ Veraflo™ Therapy (Solventum Corporation, Maplewood, MN)

Dr. Napolitano is a paid consultant for Solventum.

The author thanks Solventum for assistance with poster preparation and production.

Peel and Place Draw Down Video Examples







Novel NPWT Dressing Technology Can Drive Healthcare Improvements From Hospital to Home

Dot Weir, RN, CWON, CWS

Clinician
Holland, MI

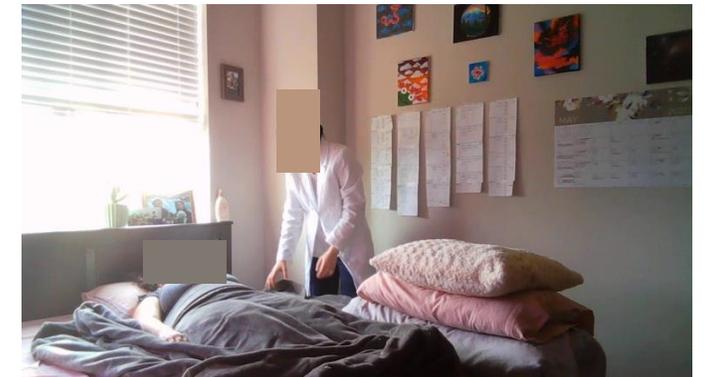
Challenges with NPWT Across Care Settings

- Discharge planning
- Frequency of visits to clinic
 - Scheduling challenges
 - Travel to clinic
 - Distance
 - Driver
 - Copays
- Home care
 - Will they accept NPWT?
 - Frequency of visits
 - Staffing



Challenges with NPWT Across Care Settings

- Dressing application
 - In-depth clinical training needed for application
 - “Arts and crafts” required
 - Foam tracking and documentation
 - Application time
 - 2-3 dressing changes per week
- Dressing removal
 - Risk of tissue ingrowth
 - Tissue disruption
 - Pain
 - Removal time



Novel Ease of Use Technology

From

To

Multiple dressing components

All-in-one, integrated design

Frequency of dressing changes (3/wk)

Up to 7 days of wear time

Need to cut foam to conform to wound bed

No cutting, ready to apply in <2min

Drape maneuverability issues

Repositionable upon initial placement

Separate steps for placement of single layer of non-adherent material

Integrated single non-adherent layer

Need to cut holes

Pre-cut hole for consistent application

Early Experiences

- Clinician Experience
 - 10/10 nurses surveyed rated the new dressing as easier to use than traditional NPWT foam dressing and a separate drape application
 - Average application time 2 minutes or less
- Less pain upon removal as no tissue ingrowth occurs
- Integrated hybrid silicone-acrylic drape easier on the skin



Value in Acute Care

- Up to 7-day wear time reduces staff time and resources
- All in one integrated design streamlines application as well as training required
 - On average less than 2-minute application time saving time in the operating room as well as on the nursing units



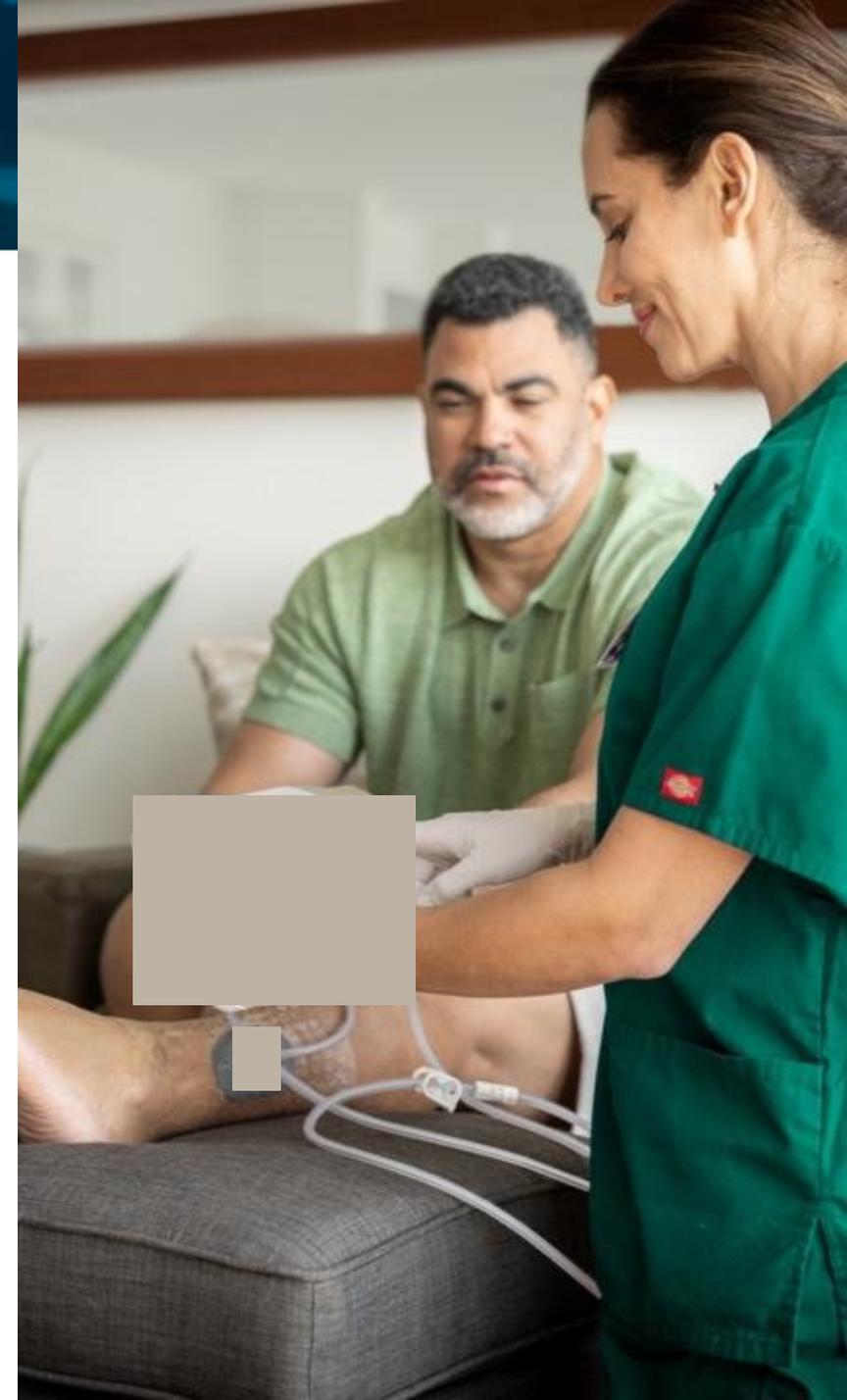
Value in Outpatient Clinic

- Up to 7-day wear time, easing clinic schedule
- May eliminate need for home health care
- Less than 2-minute application time
- If used under compression no need to reapply more frequently
- Ordering process is the same; no additional charge to payer or patient, same codes are used
 - Same codes for application in clinic

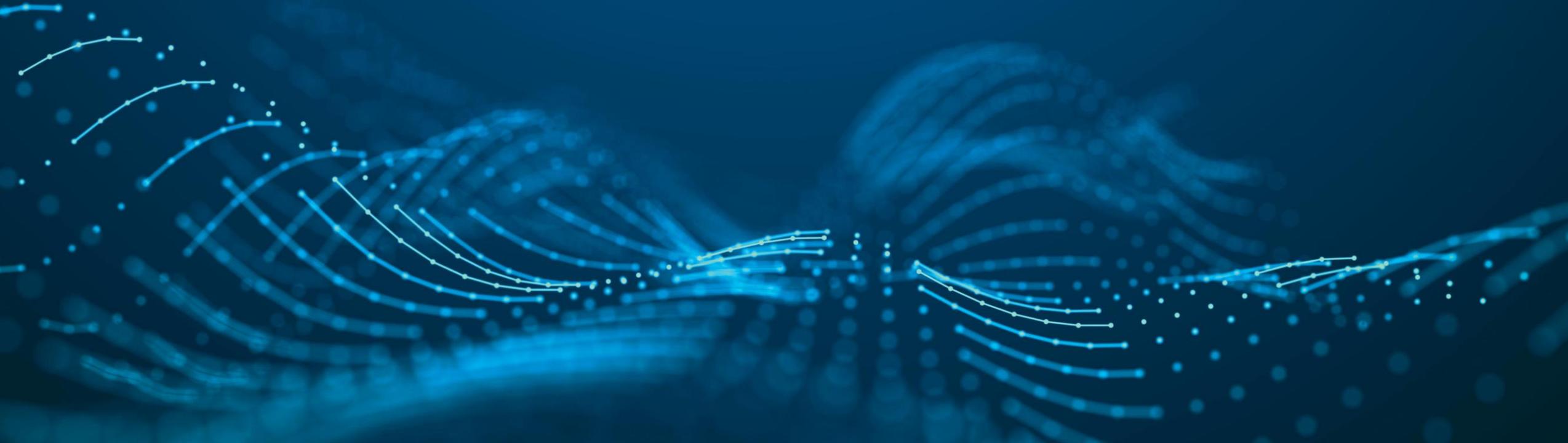


Value to Home Care Agencies

- Increased wear time means less nursing visits required
- Easier application procedure for clinicians with less experience with NPWT systems
- Less issues with pain and potential bleeding
- If used under compression no need to reapply more frequently
- Less conflict with patient's other scheduled appointments



Early Case



High Amputation

- 53y Female, heavy long-term smoking history, still 1/2 PPD smoker
- CV disease, PAD, hypertension, pulmonary issues
- High AKA after 2-3 previous failed BKAs
- 4 months post-op with most recent surgery
- Exquisitely painful, 10/10 with dressing changes
- Came to us already using powered system
- Added contact layer with promise of changing to newer 1-piece as soon as her wound size was appropriate



July 5: New Dressing Ordered

- When dressings arrived at home, patient had “transportation issue”
- Home care nurse applied first 2 dressings 7/10 and 7/15
- Our last visit (6/12) she measured 13 x 17.3 x 0.5cm (225cm²)



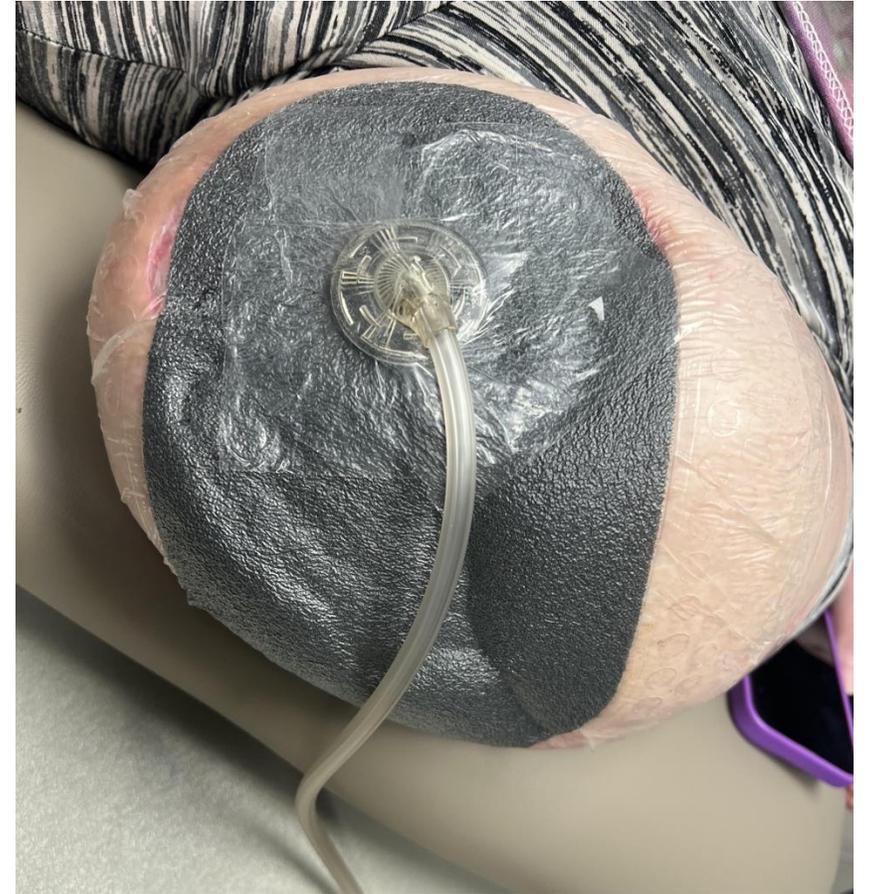
1 wk prior to placement



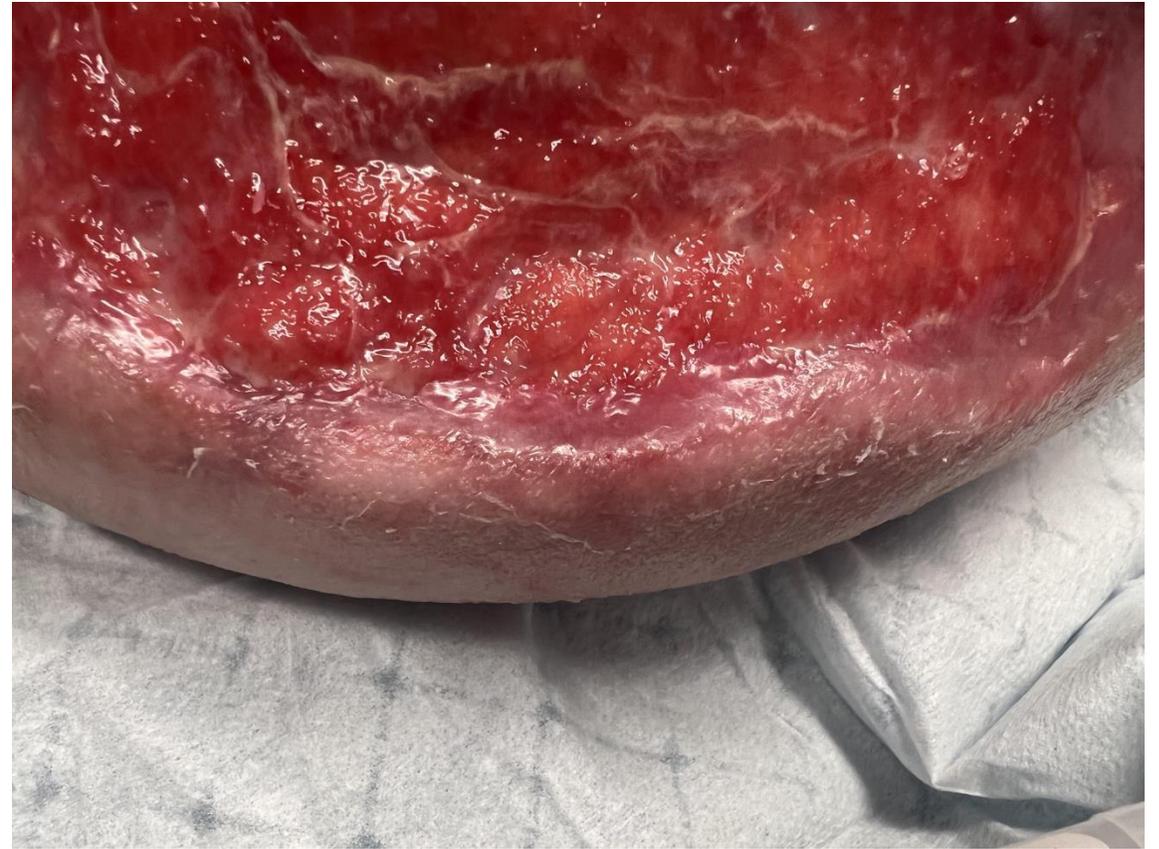
7/18 13 x 14x 0.1cm
182cm²



Zero pain on removal, zero pain on application
Applied at -150 mm Hg



1 wk: Measurements unchanged





26 days
10.5 x 9.4
182 down to 94 cm²



34 days



42 days
9 x 10cm

Took 1 day break to treat skin



43 days



49 days
9.6 x 9.5cm



55 days
8.0 x 9.0cm
72cm²

Final

- 100 days
- Moved to collagen alone, changed 2x/wk



Cases:

NPWT Toolkit Components Used In Step-Down Therapies to Wound Closure

Karen L. Bauer, DNP, CWS, FAAWC

- Director of Wound & Vascular Services, Lead APP, University of Toledo
- President, Society for Vascular Nursing
- Board Member, AAWC
- Sylvania, OH

Large Abdominal Wound Post Renal Transplant

- 65y Female, Type 2 DM with diabetic retinopathy and h/o diabetic foot ulcers
- HTN, CAD s/p old MI (2016) and CABG X 2 (9/21/2021, LIMA to LAD and reverse SVG to OM)
- HFpEF, h/o paroxysmal atrial fibrillation
- Carotid artery stenosis s/p right carotid endarterectomy (12/13/2018)
- Secondary hyperparathyroidism and anemia of CKD
- Stage 4 oropharyngeal cancer (left tonsil)
- COPD, HPL, GERD, gout, hypothyroidism, skin melanoma s/p excision
- Osteoarthritis s/p right knee replacement (2017)
- h/o right rotator cuff tear
- Anxiety, obesity, OSA (on CPAP), h/o colon polyps, diverticulosis, h/o MRSA infection, hearing loss (left ear)
- Anesthesia problems, difficult IV access
- Dermatitis, chronic sinusitis, headaches, dental disease, h/o fecal incontinence

Surgical Progression

Deceased Donor
Kidney Transplant:

July

Incisional
Infection Washout:

Consulted July 10

**NPWT: The Power of Wound Specialist Persuasion
(Getting other services to buy in)**



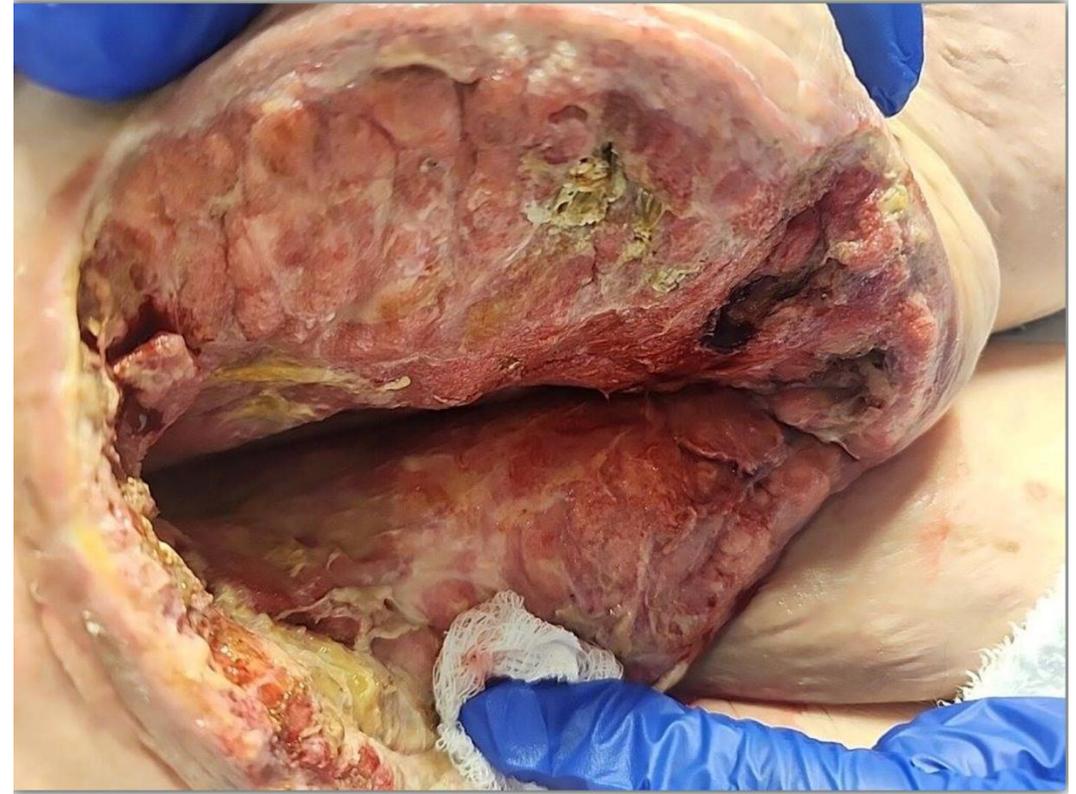
July 10



July 18

Post-Operative

- S/P 7/25 wash-out
- **Veraflo™ (NPWTi) initiated:** Cleanse Choice dressing (NPWTi-d dressing), 10min dwell time q2hrs with hypochlorous acid (HOCl), -125 mm Hg
- **Multi-Disciplinary Care:** ID, Transplant APP, Wound/Vascular, **Patient and Family**



POD 1: 2nd I&D

ECF Transition

Discharge to SNF: Aug 4

➔ ActiV.A.C.™ (portable NPWT),
Black foam, -125 mm Hg

Clinic Follow-Up Aug 14



Keys: Multi-morbid, immunosuppressed
Goal: Meticulous wound hygiene, HOCl, nutrition

Clinic Follow-Up Aug 30



Pain at wound edge
Intervention: Hydrocolloid



Transition Home

- Discharged home with Home Health
- Clinic follow-up Sept 2
- Still having pain at edges; improved
- Portable NPWT continued
- Focused on diet
- **Patient frustrated: Goal is to swim**



Multiple conversations with home health nurses



Novel NPWT

- **Oct** clinic follow-up: Started peel and place dressing
- Hypochlorous acid, collagen



Reminders for 3M™ V.A.C.® Therapy with 3M™ V.A.C.® Peel and Place Dressing

Indications

V.A.C.® Peel and Place Dressing can be used on:

- Chronic wounds
- Acute wounds
- Traumatic wounds
- Subacute wounds
- Dehiscent wounds
- Partial-thickness burns
- Ulcers (such as diabetic, pressure or venous insufficiency)
- Flaps
- Grafts

Warnings

Do not use on wounds with:

- Undermining greater than 2 cm
- Tunneling
- Depth greater than 6 cm



Find the right size

Dressing should cover the entire wound bed and extend onto intact skin.

Small - EZ5SML	Medium - EZ5MED	Large - EZ5LRG
Max wound size: 6.1 cm x 8.6 cm	Max wound size: 11.1 cm x 16.6 cm	Max wound size: 13.6 cm x 24.2 cm
Max Depth: 2 cm	Max Depth: 4 cm	Max Depth: 6 cm



Always read and follow the detailed Instructions for Use along with important safety information provided in the packaging.

Application tips for 3M™ V.A.C.® Therapy with 3M™ V.A.C.® Peel and Place Dressing



Wear time

Dressing can remain in place for **up to 7 days**.¹



Device settings

Set the device to **-75 to -150 mmHg** on **continuous mode**.

Do not

- Cut foam.
- If skin barrier/protectant is used under the adhesive portion of the dressing, do not reposition the dressing as adhesive properties may be reduced.
- Use with other V.A.C.® Therapy Dressing Kits or foams, as they have a shorter wear time.
- Push foam portion of the dressing down. Allow the dressing to draw down and conform the wound bed as negative pressure is applied.
- Stretch dressing.

Drape Tips

- Apply loosely over the wound area.
- Leave at least a 5 cm border of drape wherever possible.
- Can reposition within 20 minutes of initial application.
- For curved anatomy, slits may be cut in the drape portion of the dressing to help reduce overlap, drape folds or remove wrinkles.

Watch how-to-apply video



Customer service:
800-275-4524

Clinical support:
800-275-4524 x 56650

Technical support:
800-275-4524 x 3

NOTE: Specific indications, contraindications, warnings, precautions, and safety information exist for these products and therapies. Please consult a clinician and product Instructions for Use prior to application. Rx only.

¹SAT-BSER-05-869347 VAC Peel and Place (Ganymede) BSER. 510(k) K222859.

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Coordination



November: Peel & Place



December: Collagen



Ulcer reportedly closed → pt contracted COVID → Collagen re-initiated via telemed

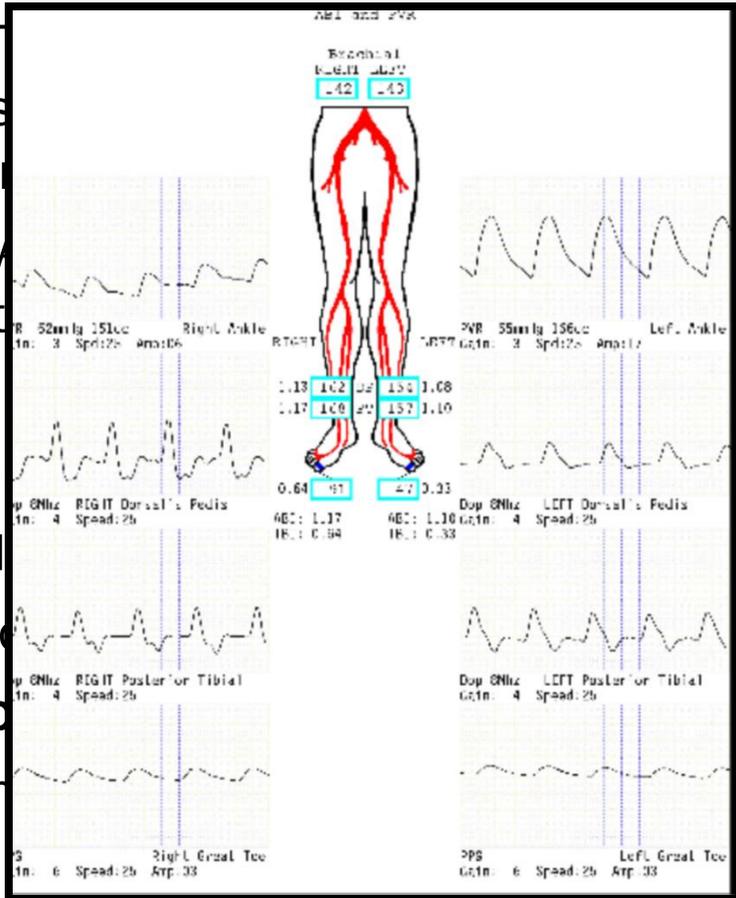
Closed



Jan 29, 2025

Atypical Vasculitis

- 68y Female
- PMH
- Pres
- anor
- CT: A
- colit
- Lap
- Rhe
- ECH
- Venc
- Biop
- High



cholecystectomy, HTN

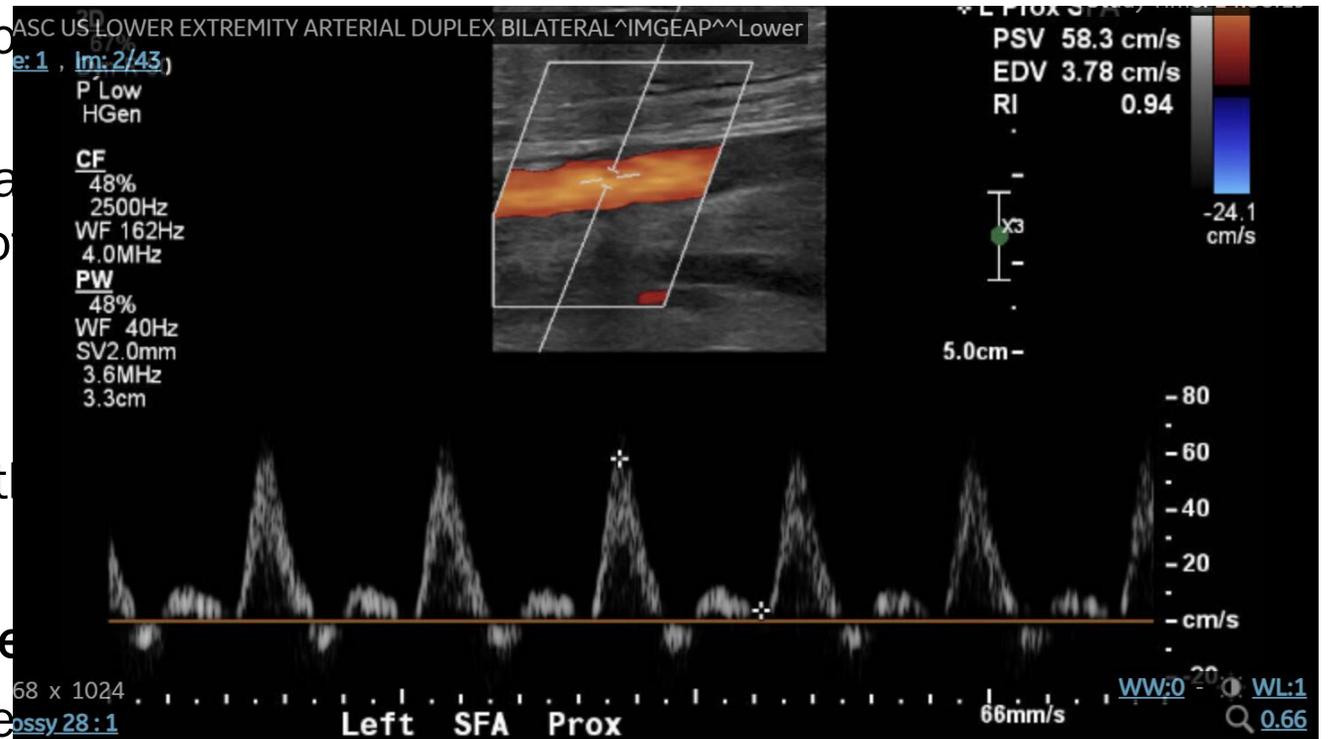
Left Iliac

hepa
nd so

g wit

howe

charge



Presentation



Presentation June 2025



3 wks later

NPWTi-d in OR → POD 5, 7-29-2024



POD 5, 7/29
NPWTi-d with HOCl
10min dwell time q2hrs at -125 mm Hg, 3x/wk

Multidisciplinary Coordination
GIM; ID; Rheumatology; Vascular

Real-World Obstacles

Challenges

- Pain control
- Health literacy
- Isolation
- Ulcer location
- Etiology not fully delineated
- NPWT varied
- **Care transition** 

Portable NPWT with nonadherent over tendon, black foam, 75 mm Hg with titration goal 125 mm Hg, as tolerated



Aug 2024

Interrupted NPWT: Consider Patient Factors!



Sept 10
NPWT held prior at ECF-
Readmitted, started peel and place



Sept 14
Discharged on portable NPWT
Non-adherent, black foam, -75 mm Hg

Multi-Modal Therapy



Oct 5

CTP/Wash-Out Booked



Oct 14

**1 wk post CTP: portable NPWT
Non-adherent, black foam, -75 mm Hg**



Oct 26

**Portable NPWT
Non-adherent, black foam, -75 mm Hg**

Inpatient to Outpatient Transitions — Coordination



Nov 24
Inpatient: Peel and place



Dec 2
Portable NPWT
Non-adherent, black foam, -75 mm Hg



Feb 12
Collagen, off dapsone

CFA Injury: Acute Limb Ischemia Post Fasciotomy

- 41y Female PMHx DM 2, PTSD, episodic mood disorder, generalized anxiety disorder, panic disorder, POTS, obesity
- Presented with RLE acute ischemia
- Open thrombectomy of right femoral artery with incision management wound vac application 9/24/24
- OR take-back for exploration of R SFA, RLE angiography, R S FA stenting, tPA catheter
- Placement and catheter-directed thrombolysis 9/25
- Lysis check that evening with RLE angiography, R AT/PT balloon angioplasty, L groin tPA
- Catheter removal with closure of access site, R leg compartment release

R CFA Injury: Attempted CVL at outside hospital

Im: 1/23

Scroll

Common femoral artery, popliteal artery, proximal and distal anterior tibial arteries.

RIGHT SIDE	Vel. cm/s	EDV	Flow	Plaque
Prox External Iliac				
Mid External Iliac				
Distal External Iliac				
Common Fem	0			
Deep Fem	0			
Proximal SFA	0			
Middle SFA	0			
Distal SFA	0			
Proximal Popliteal	0			
Distal Popliteal	0			
Prox Posterior Tibial	0			
Mid Posterior Tibial	0			
Dist Posterior Tibial	0			
Peroneal	0			
<i>Anterior Tibial</i>	<i>0</i>			
<i>Dorsalis Pedis</i>	<i>0</i>			

SAG RT CFA

9/24: Open thrombectomy R CFA with incision management system placement R groin incision

Vasc Arterial

L12-3

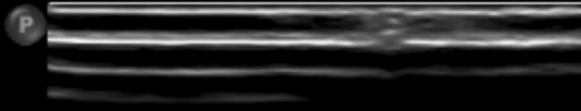
25Hz

RS

TIS0.3 MI 1.3

VASC US LOWE

ms



ARTERIAL DUPLEX BILATERAL ^IMGEAP^^Lower

70%

RIGHT SIDE	Vel. cm/s	EDV	Flow	Plaque
Prox External Iliac				
Mid External Iliac				
Distal External Iliac				
Common Fem				
Deep Fem				
Proximal SFA	17.2			Heterogeneous
Middle SFA	11.4			Heterogeneous
Distal SFA	10.5			Heterogeneous
Proximal Popliteal	11.1			Heterogeneous
Distal Popliteal	15.6			Heterogeneous
Prox Posterior Tibial	12.9			Heterogeneous

7.0cm

Right DFA NON VIS

9/25: Take-back for exploration, lysis then RLE angio with stenting R SFA and DCB of ATA/PTA, fasciotomy

9/26: VAC



Sept 30:

- VAC with non-adherent
- Black foam
- Bridge lateral wounds
- "y" connect medial
- -125 mm Hg

Transition from VAC to VAC Peel and Place



Oct 5
Peel and place dressing



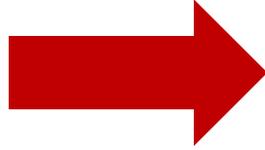
Oct 14

Outpatient Follow Up

- Discharged to home 10/20
- Home Health: Peel and place, 2 medium, -125 mm Hg 1-2x/wk
- Clinic visit 11/6 
- Also has R great toe dry gangrene
- Compression initiated, peel and place stopped
- HOCl/collagen started



Clinic Follow-Up 11/18



- HOCl, collagen,
- Non-adherent, compression



Closed Dec 17

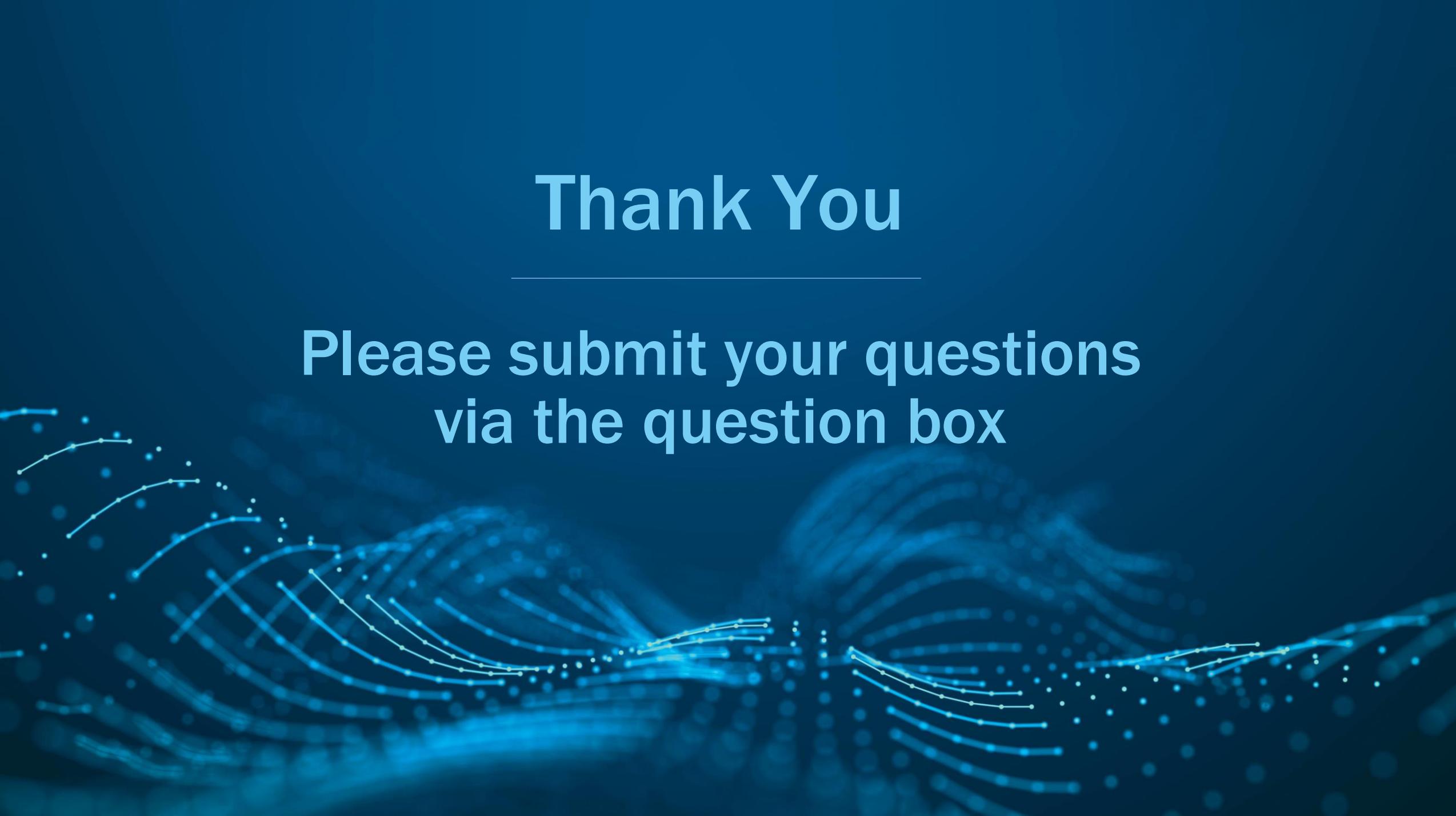


Take Home

- Clinical algorithm useful
- Need for flexibility
- Care setting
- Skill/training/comfortability of teams
- Insurance
- Patient tolerance and needs
- Step-down consideration with subsequent monitoring; can backtrack if needed
- Safety first
- Shared decision making!

Thank You

**Please submit your questions
via the question box**

The background of the slide is a deep blue gradient. It features several glowing, wavy lines of light blue and white particles that create a sense of motion and depth, resembling a digital or scientific visualization. The lines are composed of small dots connected by thin lines, and they curve and flow across the frame.