

# Eclipse Border Oval® Dressing Evaluation

**Professor Linda Rafter:** Honorary Professor in Nursing, De Montfort University, Leicester  
and Tissue Viability Nurse Consultant, Wound Care Solutions

## Case Study I

Mrs R is a 61 year old lady who was admitted to a local hospice for respite care with bilateral ulcerated lower legs on 13th September 2013. She is known to have Type 2 Diabetes, lung cancer, urinary infections and confusion. An initial assessment was undertaken using Wound Care Solutions' eHealth service every 7 days for 4 weeks. Mrs R and her mother consented to the case study and for photographs to be taken for publication.

## Care pathway

Initially, all of Mrs R's ulcers were dressed with Activon Tulle® and Advazorb® every 2 days and secured with a toe to knee bandage and Velband padding. She was nursed on a profiling bed frame to elevate her lower legs to aid venous return. She was placed on a Cirrus mattress and was encouraged to reposition herself every 2 to 4 hours. Mrs R used Tena pads for urine incontinence. She was placed on a high protein diet due to the expected high volume of exudate she would be losing from her lower leg ulcers.

The author reviewed this patient on 14th October 2013 at the hospice and her wounds had continued to improve following the eHealth consultations that started on 13th September 2013.

The right forefoot appeared to be a vascular wound. It had reduced to a 4cm x 6.5cm full thickness wound and the wound bed was 40% brown necrotic tissue and 60% yellow sloughy tissue (see fig. 1 and 2). The right big toe had a full thickness wound of 4cm x 2.5cm with 100% yellow sloughy tissue. The inner right lower leg wound was also full thickness and measured 12cm x 6cm, with 50% yellow sloughy tissue and 50% pink granulation tissue and the surrounding tissue was cellulitic. The back of her lower right leg had a 3cm x 4cm full thickness wound and the wound bed consisted of 20% yellow tissue and 80% pink granulation tissue.

The lower left leg had a 12cm x 5cm partial thickness wound and the wound bed consisted of 20% yellow tissue and 80% pink granulation tissue (see fig. 3). She has bilateral oedema of her lower legs which was pitting. The author was only able to feel pulses at her knee and her lower legs were warm to the touch. It was not possible to feel her dorsalis pedis, anterior or posterior tibial pulses due to the location of the wounds as well as the pain from the ulcers.



Fig. 1



Fig. 2



Fig. 3

At dressing changes Mrs R required Oramorph to be administered as she still had very painful ulcers. Her pain score remained at 10 on the McCaffrey scale. All of the ulcers were dressed with Actilite® and Eclipse Border Oval® dressings every 3 days and secured with a toe to knee bandage. She remained on a profiling bed frame and on a Cirrus mattress with 2 to 4 hourly repositioning. She continued with the high protein diet.

An assessment update was sent to the author using Wound Care Solutions' eHealth process (see fig. 4, 5 and 6). Following 7 days of the Activon Tulle® and the Eclipse Border Oval® dressings, Mrs R's wounds continued to improve.



Fig. 4



Fig. 5



Fig. 6

The author reviewed this patient on 28th October 2013 at the nursing home where she had been discharged. Her wounds had continued to improve following the eHealth consultation (from 20th October 2013).

As of this date, the right forefoot wound had increased and was larger at 4cm x 7.5cm but was now partial thickness. The wound bed consisted of 20% yellow sloughy tissue and 80% pink granulation tissue (see fig. 7). The right big toe had a full thickness wound of 2cm x 1cm with 100% pink granulation tissue. The inner right lower leg wound was partial thickness and had reduced to 10cm x 6cm with 100% pink granulation tissue and the surrounding tissue was considerably less cellulitic (see fig. 9). The wound on the back of her lower right leg was 2cm x 1cm and was superficial; the wound bed consisted of 100% pink granulation tissue (see fig. 10).

The lower left leg had two distinct wounds of 8cm x 5cm and 4cm x 2cm with partial thickness and the wound bed consisted of 20% yellow tissue and 80% pink granulation tissue (see fig. 11). The bilateral oedema had resolved completely and the surrounding skin appeared to be very dry and required an emollient cream. Her pain score on the McCaffrey scale had reduced to 4. She continued to be nursed on a profiling bed frame but was moved to a Karomed Transair alternating mattress and encouraged to reposition herself every 2 to 4 hours.



Fig. 7



Fig. 8



Fig. 9



Fig. 10



Fig. 11

## Nurses' feedback

The hospice nurses found the dressing easy to use and liked the new oval shape of the familiar Eclipse® range. They found that the dressing had managed the exudate well with the dressing changes performed every 3 days. The nursing home staff also liked the dressings, but they had not used the Eclipse® dressing range previously. They liked the Eclipse Border Oval® dressing and they had found it simple to use and easy to apply and could see an improvement with wounds 7 days later.

## Conclusion

Due to Mrs R being confused it was impossible to gain her comments. The photographs demonstrate an overall improvement in the wound after using the new Eclipse Border Oval® dressing. The author found that dressing removal and application were easy allowing for good wound bed contact. This patient's pain had decreased as the wounds healed and she required less analgesia. Whilst this is only one case study it does appear that the new Eclipse Border Oval® dressing could be a very useful addition to the Eclipse® range.