# Multilayering of superabsorbent polymer dressings has no place in wound care

Dear Editor,

In spite of many years of research and teaching, I have come to realise that some clinical practices are difficult to eradicate. One particular practice is the use of multilayered combinations of wound dressings often made up of components with very different functions. No doubt, the multilayering of dressings is ostensibly for the convenience of the clinician and with no, or little, consideration for the patient.

Carefully considered, clear guidelines for the appropriate selection and use of dressings have been published widely (e.g. Thomas, 1997; Young, 1997; Day et al, 1998; Loftus and Wheatley, 2000; Clarkson, 2007; Stephen-Haynes, 2011) We have encountered dressing 'sandwiches' over many years, despite the complete lack of evidence. The layering of fibrous, absorbent dressings, together with antimicrobial dressings is one example of a dressing 'sandwich'. Antimicrobial dressings will only exert their effect when in direct contact with the wound bed, not when superimposed on one or more absorbent products. Such practice is unjustified in clinical and economic terms.

We have also observed, with increasing regularity, the multilayering of superabsorbent polymer dressings (SAPs). Evidence tells us that these products can absorb large quantities of exudate (Tarlton and Munro, 2013; Wiegand and Hipler, 2013) and, by inference, swell and become heavy. Care should be taken to ensure that the dressing does not reach saturation point, as this may lead to damage of the peri-wound area and the development of maceration and wound enlargement. While evidence for their use under compression bandaging is sparse (Cook, 2011), there is no evidence regarding sub-bandage pressures generated when SAPs are layered. This practice has the real potential to cause damage, and should be avoided until evidence becomes available, if ever. Where wounds are very heavily exuding so as to warrant SAP use, it would be better to make more frequent visits to the patient for dressing change rather than to leave the patient with a bulky dressing, unsupervised clinically, until a visit becomes convenient for the clinician. Where wounds become highly exuding, extra caution is required to ensure that maceration and possible infection can be avoided. This will not be achieved by infrequent visits.

What do these bizarre practices tell us about the clinician? First, that the clinician is not acting on the basis of evidence. Second, the clinician has not undertaken any recent training or education on wound management. Third, the clinician is not acting according to the instructions for use in any modern dressing packaging. Finally, the clinician is unlikely to be considering the patient-related problems of comfort, leakage, and pain caused by inappropriate dressing selection and use.

The issue of mixing dressings is a serious one. The use of a dressing against the manufacturer's recommendations puts the nurse in an extremely vulnerable position (Young, 1997).

The final word is that of Krasner, who stated in 1996:

> 'Product categories cannot be combined haphazardly; however, the clinician must be certain that products can be safely combined and will not harm the patient.'

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**What are your thoughts on multilayering of superabsorbent polymer dressings?**
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