The long term use of honey dressings on ischaemic feet

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Mr T is a 54 year old gentleman who was admitted to hospital on 05/12/2005 with small bowel obstruction. He had a Right Hemicolectomy on 07/12/2005 but returned to theatre 2 days later for a Laparotomy and formation of end ileostomy with mucus fistula following an anastomotic leak and faecal peritonitis. He was then diagnosed with Crohns Disease.

He spent 4 weeks in the Intensive Care Unit with multi-organ failure and developed ischaemic damage to his feet secondary to the inotropes he was given. Resting ankle brachial pressure indices were normal.

He also suffered with septicaemia, MRSA, malabsorption and weight loss for which he was given Total Parental Nutrition via a central line and then later on he was fed via a naso-gastric tube.

Mr T was referred to the Vascular Nurses on 21/07/2006 for advice on wound dressings.

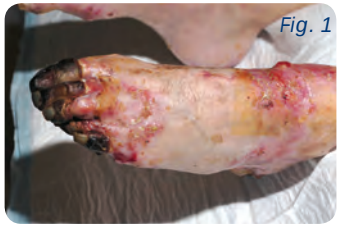


Fig. 1

On examination the heels and some toes were hard and necrotic but there were superficial granulating wounds on the top and soles of his feet. We started using Activon® Tulle to the top and soles of his feet and Algivon® to his black toes and heels. We redressed the feet twice a week and used a foam dressing as a secondary dressing to absorb any exudate and for the patients' comfort and protection when transferring in and out of bed. There was significant necrotic tissue to all the digits on the left foot. This heel was also sloughy (50%) and necrotic (50%) (fig: 1+ 2). The top of this foot was a grade 1 in presentation. The second, third and fourth toes on the right foot were necrotic. The big and little toe had intact skin. The right heel was also 70% necrotic; the other 30% was a grade 2 in presentation. The top of this foot was also grade 2 in presentation (fig: 3).

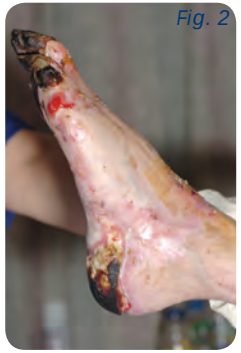
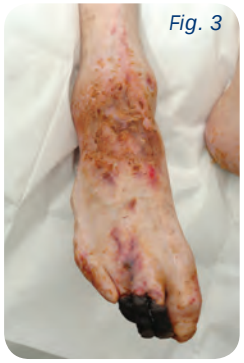


Fig. 2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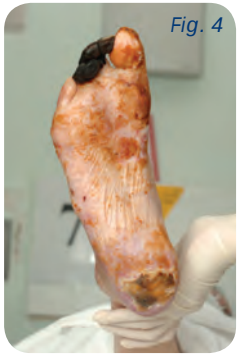
Fig. 4

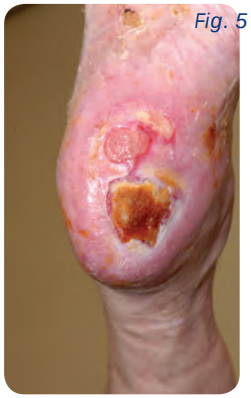
Fig. 5

On 08/08/2006 he returned to theatre again for a Laparotomy and an enterocutaneous fistula with small bowel resection and reformation of the ileostomy. The heels were sharp debrided by the Podiatrist on 14/08/2006. Even though the heels had been sharp derided so the necrotic tissue had been totally removed and the sloughy area was reduced by 20% to both heels. By the 20/08/2006, just 4 weeks after starting the honey, the top and soles of his feet were healed. These were redressed with either N/A or Mepitel but we continued to redress the heels and toes with Algivon® (fig: 4).

In October 2006 Mr T was discharged to a Rehabilitation Unit as he was still very weak and not gaining weight. The feet were still redressed twice a week with honey.

Four months later some of the black toes had self debrided and in April 2007 Mr T attended the out-patients department to see the Vascular Consultant who arranged for the remaining black toes and right distal hallux to be amputated as Mr T was finding it increasingly painful to walk due to the claw toe on his right foot.

Mr T was discharged from the outpatients department in August 2007 but the District Nurses were continuing to redress the heels twice a week with Algivon® (fig: 5 + 6). Despite Mr T being in hospital for 10 months and developing numerous problems and complications, his feet have almost healed using honey and he able to walk and lead an active life.

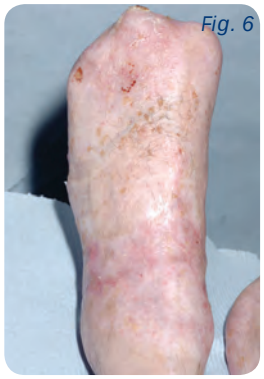
Fig. 6

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