

The use of Medical Grade Manuka honey to facilitate auto-amputation fingertip necrosis

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Introduction

A 57 year old male presented initially to the GP on 9th September 2014 with blue fingertips to one hand and Raynauds was queried. At this time both radial and ulnar pulses were present and the patient was hypertensive. Two weeks later he presented to A&E with a necrotic middle fingertip. A duplex scan showed a thrombus in the distal ulnar artery with a non-occlusive thrombus in the distal radial artery. A&E referred the patient back to the GP practice with a recommendation of a povidone-iodine dressing and dry secondary dressing. He was commenced on Dalteparin (anti-thrombotic), advised to wait for the fingertip to auto-amputate and was initially seen by District Nurses who continued this dressing regimen.



Method

On 2nd October his care was taken on by the Practice Nurse who noticed a strong malodour which was distressing to the patient and family. A week later an area of slough developed above the necrotic fingertip and the wound became wet. The patient was switched to Algivon® Plus Ribbon (Medical Grade Manuka honey alginate dressing) as an iodine dressing was ineffective at dealing with malodour and wet slough and this dressing would prevent infection, control the malodour and facilitate auto-amputation of the fingertip. The Algivon® Plus Ribbon was wrapped circumferentially around the finger with another over the top of the fingertip extending down the sides. This was secured with a foam secondary dressing and finger bandage. The wound was very painful requiring Oramorph prior to dressing change. The patient was seen twice weekly for dressing change and ongoing assessment.



Results

By 11th November the wound was still wet and sloughy with no malodour and the necrotic tip was beginning to detach. Algivon® Plus Ribbon was continued to deslough the wound and facilitate auto-amputation. The dressing was well tolerated and dressing changes became less painful with Oramorph being discontinued by the end of November. The tip was now dry and on 5th December the patient was changed to a povidone-iodine dressing to encourage the wound to dry out. However by 16th December the wound became wet again and Algivon® Plus Ribbon was recommenced. The fingertip detached on 24th December. Algivon® Plus Ribbon was continued until 6th January 2015 when the wound was found to be dry and a foam dressing was used for protection. Vascular services at the local hospital were pleased that although the topography of the fingertip was irregular all tissue had epithelialized. The patient was advised to dispense with all dressings and to exercise the fingertip as much as possible to encourage the soft tissue to settle before referring for plastic surgical intervention.

Discussion

This was an extremely unusual case as auto-amputation usually occurs in toes whereas this patient still had to function and use his hands during the treatment period. Waiting for a digit to auto-amputate is very distressing seeing your body fail in front of your eyes and the patient had to endure this for a period of 3 months. Auto-amputation normally takes place in



a dry wound environment. However for this patient the body's natural propensity to debride its own necrotic tissue meant that the necrosis started to soften naturally. This resulted in a wet sloughy, painful and malodorous wound which meant that the normal wound management plan had to be adapted. The practice nurse worked with the Director of the Welsh Wound Innovation Centre to produce a management plan that was patient focussed and alleviated the distressing symptoms. Algivon® Plus Ribbon was well tolerated, cost-effective and facilitated the safe auto-amputation of this digit.

Conclusion

This case study demonstrates how an individual faced with the distressing situation of having to wait for a necrotic fingertip to auto-amputate was able to be treated with a dressing that ensured his concerns about pain and malodour during this process were alleviated. This is a good example of how a collaborative approach worked in the absence of any previous experience of this wound presentation. At all times the patient was the focus of the wound plan and keeping the wound free from infection allowing daily life to continue for the patient was of paramount importance. The additional advantages of the antimicrobial dressing were the reduction in malodour and pain.

This case study is supported by a consecutive series of photographs demonstrating the distressing wound the patient had to face during the treatment period and the challenges faced in providing a dressing regimen that maximised patient independence.

There are no conflicts of interest declared in this case study.