

Dressing Selection Guide by Wound Condition

B/Y/R	Yellow			Red				Pink		
Wound Appearance										
Description	Eschar* (Colors may vary)	Predominantly Slough (Infection may be present)	Granulating/ Mixed Wound Tissue	Fibrin (Appears yellow)	Granulating and/or Epithelializing	Skin Tear	Epithelializing	Healed Wounds, Skin at Risk or Closed Surgical Incisions	Hypertrophic or Keloid Scarring	
Exudate Level	Moderate to None		High		to Moderate		Moderate		to Scant	None
Depth	Unknown	Deep	Deep/Shallow	Deep/Shallow	Deep/Shallow	Shallow	Shallow	Closed	Closed	
Treatment Objective	Debride*	Cleanse, Debride, Absorb, Fill Dead Space			Protect, Hydrate, Fill Dead Space				Protect	Reduce Scarring
Suggested Products and Change Rates <small>To the right are management options for each wound condition</small>	Hypergel® (daily) Cover choices: Alldress® or Mepore® Pro or Mepilex® Border or Mepilex® Border Lite	Mesalt® (daily) Melgisorb® (Up to 3 days) Cover choices: Alldress® or Mepilex® or Mepilex® Border	<u>Deep</u> Mesalt® (daily) Melgisorb® (Up to 3 days) Cover choices: Alldress® or Mepilex® Border	<u>Moderate Exudate</u> Melgisorb® (Up to 3 days) Cover choices: Alldress® or Mepilex® Border	<u>Moderate Exudate</u> Melgisorb® (Up to 3 days) Cover choices: Alldress® or Mepilex® Border	<u>Contact Layer</u> Mepitel®* (Up to 10 days) or Mepilex® Border (Up to 7 days) Mepilex® Border Lite (Up to 7 days)	Mepitel®* (Up to 10 days) Mepilex® (Up to 7 days) Mepilex® Border (Up to 7 days) Mepilex® Border Lite (Up to 7 days) Mepilex® Lite (Up to 7 days) Normlgel®† and Alldress® (Up to 2 days) Mepore® Film (Up to 7 days) Mepore® (PRN) Mepore® Pro (PRN)	Mepilex® Border Lite Mepilex® Lite (Up to 7 days) Mepore® Film (Up to 7 days) <u>Post Surgical</u> Mepilex® Border Post-Op (Up to 7 days) Mepore® (PRN) Mepore® Pro (PRN) <u>Radiation Dermatitis</u> Mepilex® Lite (Up to 7 days) Mepilex® Transfer (Up to 7 days)	Mepiform® (Up to 10 days per dressing) Remove daily for inspection and cleansing of the skin	
	Consider using ● Mepilex® Ag or ● Melgisorb® Ag when antimicrobial effect is required									
Notations	<ul style="list-style-type: none"> ✦ Mepitac®, Mefix®, Mepore® Film, or Tubifast® for additional fixation. ✦ Normlgel® may be used to donate moisture. ✦ Mepilex® Transfer: Secondary dressings needed for exudate management PRN. 				<ul style="list-style-type: none"> ✦ Safetac® soft silicone technology dressings do not require use of skin barrier products. ✦ Mepitel® - May irrigate or apply ointments over contact layer. Change secondary cover dressing PRN. ✦ Mepilex® Border Sacrum - For sacral wounds 					


Individuals with wound infection or those at high risk for infection may require more frequent changes as well as adjunctive antibiotic therapy. Before any healing process can begin, two critical steps must be taken as part of a well-defined management protocol:






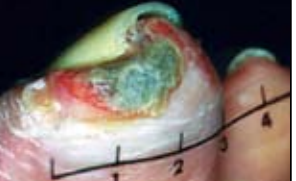
1) The wound assessment and 2) Management of causative and contributing factors including unrelieved pressure, shear and friction, excessive moisture and altered nutritional status.

* Debridement of eschar may be contraindicated in some situations such as dry, fused, stable eschar. Debridement is indicated if signs/symptoms of infection are present.

† Normlgel-when packing wound space, impregnate gauze with Normlgel, loosely fill and cover.

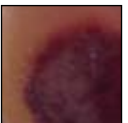





‡ Normlgel, creams, or ointments may be applied over Mepitel as indicated. Mepitel may be left in place during wound cleansing and irrigation. Change secondary dressings as needed.

Color Concept B lack/ Y ellow/ R ed		Eschar and yellow adherent nonviable tissue; dry to moderate exudate		Moist necrotic slough (may be yellow, beige, or grey in appearance); moderate to large amount of exudate		Granulating and/or epithelializing tissue; scant to minimal exudate
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Lower Extremity Ulcers	Definitions	Venous Insufficiency	Arterial Insufficiency		Neuropathic (Diabetic)		
	Wound Appearance						
	Clinical Appearance	<ul style="list-style-type: none"> ◆ Red/ruddy base ◆ Presence of yellow fibrin ◆ Irregular edges ◆ Moderate to heavy exudate with peripheral tissue edema ◆ Pulse (may be difficult to assess secondary to edema) ◆ Brown discoloration to affected area (hemosiderosis) ◆ Scarring from previous ulcers may be observed 		<ul style="list-style-type: none"> ◆ Well defined and even edges ◆ May be deep (tendons often visible) ◆ Little or no granulation ◆ Minimal to no exudate ◆ Dry cracked skin ◆ Pain: intermittent or chronic ◆ Thickened toenails ◆ Pale wound base 		<ul style="list-style-type: none"> ◆ Necrotic tissue common ◆ Skin cool around and distal to ulcer ◆ Induration around wound margins ◆ Shiny, taut, thin dry skin ◆ Hair loss on ankle and foot ◆ Dependent edema, elevational pallor 	
Management Guidelines	Compression and Elevation		Maintain legs in a neutral or slightly dependent position. Avoid debridement or compression (for mixed disease) until perfusion status is determined		Orthotics, non-weight bearing; avoid constrictive garments and exposure to extreme temperature		

Definition of Pressure Ulcer Stages[†]

† National Pressure Ulcer Advisory Panel, 2007

Deep Tissue Injury	Stage I	Stage II (Partial Thickness)	Stage III (Full Thickness)	Stage IV (Full Thickness)	Unstageable
					
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.	Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

The information provided herein is not to be construed as the practice of medicine or substituted for the independent medical judgment of a patient's treating physician. This information, including but not limited to suggestions for product wear time, product selection and suggested use is based on generalizations and does not consider the unique characteristics of an individual's wound. Each patient's physician shall remain solely responsible for assessing the severity of patient wounds, determining the appropriate treatment, and managing treatment of the wound. For additional information, please refer to the applicable product insert or contact Mölnlycke Health Care at 800.882.4582.

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US023440809 - 210002P 09.08