Case study using LarvE BioFOAM™ dressing

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Rosalyn Thomas is Chief Podiatrist, Morriston Hospital, Swansea.

Mr T is a 58-year-old male with poorly controlled type 1 diabetes with an HbA_{1c} of 9.2%. He has retinopathy, nephropathy, neuropathy and has recently undergone a coronary artery bypass graft. He also has a history of a slow-healing foot ulcer and Charcot foot. He is a non-smoker and a social drinker.

Mr T originally attended the podiatry department as an emergency patient in August 2007 presenting with dorsal blisters on his right 3rd and right 4th toes caused by the worn lining of his surgical shoes rubbing his toes.

The blisters were initially dressed with Inadine™ and Primapore™ and Mr T was issued with a temporary Darco™ boot. The Surgical Appliances Department was contacted in order to measure and supply new footwear.

After 1 week the blister on the right 4th toe had resolved but the right 3rd had developed a dark eschar with cellulitis spreading to the dorsum of the foot. A prescription for antibiotics was issued by his GP and the ulcer was swabbed and the toe re-dressed with Inadine™.

At each subsequent visit the foot was photographed and the wounds were traced with Opsite™. Over the next few weeks the wound became sloughy: therefore, after discussion with the individual regarding the best way forward, a decision was made to use a LarvE BioFOAM™ dressing.

Mr T attended the podiatry clinic on Monday 22 October 2007 for the LarvE BioFOAM™ dressing to be applied (*Figure 1*) and was given a follow-up appointment for the Friday of that week with instructions to contact the clinic if any problems or concerns arose before that day.

On his return visit the wound bed had been transformed from a sloughy area to bright red healthy tissue with the tendon clearly visible (*Figure 2*). Mr T commented that he felt no discomfort while the LarvE BioFOAM™ dressing had been applied to the wound and was very pleased that the treatment had been successful. The toe was then dressed with Prisma™ and Primapore™ and he was happy to re-dress his own toe between visits to the podiatry department.

By 7 December 2007 the wound had resolved, much to the relief of Mr T and the podiatry team, despite his multiple co-morbidities and the history of delayed wound healing (*Figure 3*). The wound has now healed nicely (*Figure 4*).

This was a wound not usually associated with the use of biosurgery and consequently many practitioners would perhaps have thought that the clinical situation did not warrant the use of such therapy since most of the case studies published to date feature more complex wounds. However, this wound had the potential to impact detrimentally on the individual's quality of life, perhaps even leading to the eventual amputation of the affected digits. Under these circumstances why not use maggot therapy to treat 'simple' wounds to prevent them becoming complex, life threatening and time consuming to treat? ■

Figure 1. The wound on 22 October 2007 immediately prior to LarvE bioFOAM™ dressing application.

Figure 2. The wound on 26 October 2007.

Figure 3. The wound on 7 December 2007.

Figure 4. The wound on 11 January 2008.