Correspondence

Critical colonisation theory needs solid evidence to be accepted by sceptics and clinicians

Richard White, as usual, has provided an extensive body of literature to support his comprehensive critique of the challenges associated with diagnosing wounds that are not healing because of problems with the patient's host response, or where bacteria delays healing (*Wounds UK* Correspondence **2(2):** 86–88). Although many clinicians who work in wound care find the concept of critical colonisation helps their clinical practice, there are many other clinicians and researchers in other areas who remain sceptical, if not dismissive, of both this term and the concept that wounds do not heal due to bacterial infection even when the patient does not exhibit traditional signs of infection.

Many research studies are required to investigate this concept to develop a way of diagnosing this clinical state with accuracy and reproducibility. Once this challenge has been addressed, the studies to determine and develop the best treatment method for this condition can be considered. In addition to the use of traditional topical and systemic antimicrobials, the evaluation of agents that modify the patients immune response, disrupt biofilms or stimulate an additional wound healing response can be undertaken. The challenge exists, therefore, for the proponents and believers of critical colonisation to provide solid definitions and data so that the concept can gain acceptance, and for it to be recognised as a clinical state. Then it can be embraced by all groups of clinicians and researchers.

Keith Harding, International Editorial Advisor and Head of the Wound Healing Research Unit, Cardiff

The WIC will be adapted as we learn more about the causes of delayed healing

Dr White's letter raises a number of important issues that have an impact on theory and practice in wound care. First, the Wound Infection Continuum has been developed as a model to help guide practice. It is important to remember that clinical models are not reality but are proposed representations of reality. This continuum is, therefore, likely to be adjusted in response to advances in knowledge. Dr White made the extremely important point that critical colonisation has yet to be definitively characterised. It would be somewhat short-sighted for definitions of critical colonisation to be published without the supporting scientific background.

Dr White's letter also brings into sharp relief the importance of 'delayed healing' as a sign of infection. Hitherto, this has been regarded as a healing complication, rather than as a sign of unsustainable bioburden. Admittedly, other causes of delayed healing exist, such as poor nutrition, smoking, co-morbidity, but it is interesting to note that in a publication (Cutting and White, 2005; *Ost Wound Management* **51(1):** 28–34) where clinical signs of infection were generated by expert panels for six wound types, four of those panels clearly identified delayed healing as a sign of infection. The two wound types where delayed healing was not identified were arterial ulcers and burns wounds (full- and partial-thickness).

The other important issue is that we need to learn more about how bacteria actually bring about delayed healing. This is perhaps not important in a clinical sense, unless the bacterial processes of delayed healing lead us to learn more about the clinical signs of infection, which is how the wound tells us that the bioburden is impinging on healing.

Of course, this response cannot end without a mention of biofilms. It is likely that biofilms will be found to be implicated in all chronic wounds and this will have obvious implications for management.

Keith F Cutting, Clinical Editor and Principal Lecturer, Buckinghamshire Chilterns University College

Research project needs clinicians who have experience of therapeutic ultrasound

We are carrying out research related to the treatment of wounds using therapeutic ultrasound. This form of treatment has been quite widely used in the UK in the past, but is not used much at present, despite research evidence in its favour for particular types of wound. In many studies, ultrasound has been applied to the periphery of the wound, few have looked at treatment of the wound area itself, partly because of concerns about disturbance of the wound by the movement of the ultrasound head, and because of worries about infection. Our area of interest is in the ability of wound dressings to transmit ultrasound, so that treatment can be carried out with the dressing in place. With insonation of the wound bed itself rather than the periphery, the treatment might be more efficacious.

We would be keen to hear from anyone who has used, or is using therapeutic ultrasound in the management of any type of wound — venous or pressure, diabetic or traumatic, surgical or burns — in order to gauge current use and views of this treatment approach.

Leon Poltawski, School of Health & Emergency Professions, University of Hertfordshire

Generic products do not compromise patient care but do reduce costs

I read with interest the editorial by Pauline Beldon entitled *Patients will pay for NHS Short-sighted Penny Pinching* (*Wounds UK* **2(2)**: 10). As the CEO of Advanced Medical Solutions, I was surprised by a number of Ms Beldon's comments, particularly her suggestion that all less expensive or generic products are of a lesser quality than more expensive options, and it is impossible for trusts to save money without compromising patient care or cutting back clinical staff. This is not my experience at all. Independent clinical evaluation has found that AMS' generic range of advanced wound care products, ActivHeal®, reduces the cost of treating wounds while maintaining the quality of wound care.

At a time of severe funding pressures within the NHS, which is impacting upon nurses' hours and posts, the balance between short-term cost savings and long-term patient care is clearly critical. As a 'company who produces cheaper products', as referred to in the article, without compromising patient care and who provides all necessary help with changes in formulary and additional staff training, we are more than aware of the balance that needs to be made. While value for money does not always mean using the cheapest option, there is a need to look at cost effectiveness given the constraints on NHS funding. To this end, where there are generic versions of products, they should be considered for use.

We have been working with NHS trusts to deliver significant savings in their wound care spend, and have already successfully delivered savings to ten NHS trusts in total, while providing all necessary support and training. We have had no reports of the quality of patient care being adversely affected in any way. In fact, many nurses report that the use of ActivHeal® advanced wound care dressings make selection of the appropriate dressing for the patient much easier.

Don Evans, CEO, Advanced Medical Solutions Group