Revising wound dressing classification

Keith F Cutting

Wound dressing classification has traditionally focused on the dressing ingredient(s) leading to the construction of a list that emphasises the dressing constituents, e.g. alginates, foams, hydrocolloids, hydrogels, etc. Wound dressings' origin lies in natural sources when honey, lard or butter were applied and would have been kept in place with leaves and/or grass (Forrest, 1982). Some ancients used tree resin to cover and protect the wound surface (Forrest, 1982). This ingredient-based approach is attractive because it is simple and easy to use, and facilitates choice of dressing within the confines of any specific clinical situation, while also allowing pharmacy/medicines managers to 'supervise' expenditure by dressing category.

Unfortunately, simplicity and ease of use does not lend itself, in this situation, to the provision of details indicating mode of action or potential clinical outcomes, theoretically important 'ingredients' of dressing choice. This disadvantage becomes apparent when noting that same category dressings will have varying properties with the potential for related variance in clinical outcomes. For example, Algosteril® (Systagenix), Comfeel® Alginate (Coloplast), Kaltostat® (ConvaTec) and Sorbsan (Agren, 1996) have been found to have variances in lateral spread of wound fluid, fluid retention and adherence to the wound, all of which possess the potential to influence outcomes.

Keith F Cutting is Clinical and Business Director, Perfectus Medical Ltd, Daresbury, UK; Principal lecturer, Buckinghamshire New University, Uxbridge, UK

This quandary of the most appropriate pathway to dressing choice has been lingering in the background since van Rijswijk (2006) suggested that the ingredient-based approach to wound dressing classification is out-of-date, in need of replacement, and even counter-productive when considering the development and clinical use of advanced dressing technology. Van Rijswijk also identified that in other areas of healthcare, products are chosen from a basis of function, e.g. diuretic, anti-inflammatory, antibiotic, not ingredient-based, and that in an age where the demand is for practice to be evidence-focused, the use of a predominantly ingredient/feature approach appears to be particularly archaic. Although clinicians are familiar, if not generally dependent on the ingredient-based approach to dressing categorisation, it is interesting to note that this method is not universally used throughout the 'industry'. In the UK Drug Tariff (www.ppa.org.uk/ppa/edt_intro.htm) Part IXA (Dressings), the reader will find a mixture of ingredient- feature- and function-based categories, for example, gauze dressings, absorbent pads and, atypically, protease modulating matrix. This latter category is distinctive, almost quirky in nature, directly reflecting putative function and ignoring ingredient(s). Indeed, in this novel form of categorisation, a raft of product constituents will be found including collagen and oxidised regenerated cellulose, hydrofiber, and cadexomer iodine among others. This departure from tradition raises questions, not least, what was the motivation for the generation of such an idiosyncratic category? Could it be that industry has identified clinical outcomes as an important consideration in dressing selection? Or, is it that an embellished pricing structure can be appended to products placed in a progressive/advanced style of wound dressing category?

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Irrespective of initial motivational factors, clinicians need to review the value of the current system of wound dressing category by ingredient. In the current era, where planned care is designed to deliver identified outcomes, clinicians should earnestly consider that an outcomes-based approach to categorisation can assist in the selection from the myriad of dressings available. WUK

References

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