Upcoming Events. . .
and important dates in your State

AWMA
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QUEENSLAND

4th Indigenous Health Conference
Date: 1-3 December 2015
Venue: Shangri-La Hotel, Cairns
Speakers: Deadly First Nation's guest speakers from Canada, New Zealand & Australia
Further details: http://www.indegenousconference.com/
email: admin@indigenoushealth.net

International Indigenous Allied Health Conference 2016
Date: 1-3 December 2016
Venue: Pullman Hotel, Cairns
Further details: http://www.indegenousconference.com/ email: admincs@iinet.net.au

February Twilight Education Session
Date: Tuesday 23 February 2016
Venue: TBA - Gold Coast Interest Group

May Twilight Education Session
Date: Thursday 26 May 2016
Venue: TBA – Brisbane

September Twilight Education Session
Date: Tuesday 6 September 2016
Venue: TBA - Gold Coast Interest Group

Wound Awareness Week
Date: Saturday 12 March 2016
Venue: Toowoomba
Full Day Program

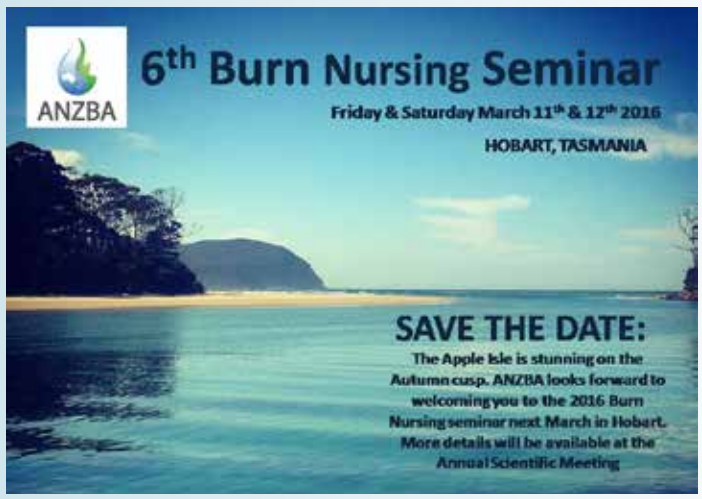
Science Week Seminar
Date: Saturday 13 OR 20 August 2016
Venue: TBA - Brisbane
Full Day Program

AWMA QLD Christmas Event
Date: December 2016
Venue: TBA

TASMANIA

5th Burn Nursing Seminar
Date: 11 & 12 March 2016
Venue: Bahai Learning Centre, Hobart
Further details: http://anzba.org.au/anzba-burn-nursing-seminar-2016/

AWMA (TAS) Education Day
Date: Saturday 23 April 2016, 8:30 – 16:00
Venue: Grand Chancellor Hotel, Hobart, with an IT link to Launceston, Tram Sheds.



VICTORIA

AWMA National Conference 2016
Date: 9-12 November 2016
Venue: Melbourne Convention Centre
Further details: www.awma2016.com.au

WESTERN AUTRALIA

Western Australia Pressure Injury Education Forum
Date: Friday 11 December 2015
Venue: Bruce Hunt Lecture Theatre, Royal Perth Hospital - Wellington Street, PERTH
Keynote speaker: Prof Keryln Carville

AWMA (SA) MEMBER PROFILE . . .

Carolyn Miller

I have worked in the area of wound management as a podiatrist since graduating in 1987.

As a private practitioner in Adelaide, I have a focus on chronic disease management (particularly diabetes) and the prevention, education and management of the high risk foot. As a part-time employee of Australian Regional and Remote Community Services (formerly Frontier Services) for 27 years, I work on a monthly basis in Alice Springs. I am exposed to a very diverse patient population, often presenting with almost inconceivable lower limb wounds requiring podiatry interventions and inventive wound and pressure management strategies. This environment provides a constant source of professional stimulation and continual review of the limb salvage vs. lower limb/foot amputation treatment options.

I spent 20 years working part-time in Domiciliary Care SA, initially working at the Lyell McEwin Podiatry Department and Northern Domiciliary Care. I was the first Clinical Advisor-Podiatry (2006-2008) providing clinical advice for the Clinical Governance Framework in conjunction with other allied health disciplines. My role included the development and maintenance of professional competency standards for podiatrists working in the domiciliary environment.

As a qualified training supervisor I provide in-service training to allied health professionals, registered and enrolled nurses and carers. The most recent presentation: *Maintaining Skin Integrity in the Foot/Lower Limb*, was focussed on preventative strategies and accountability of care. I was formerly a part-time lecturer and clinical supervisor for the UniSA Podiatry Program.

As a member of the Podiatry Board of South Australia from 2006 to 2009 I was on the sub-committee for the Continuing Education Guidelines for Podiatrists. I look forward to serving as your committee member for AWMA (SA).

Carolyn Miller, Podiatrist

Please email any comments or suggestions regarding this report to:
newsletter@awma.com.au

Case Study

The Consequences of Postoperative Infection on Flexor Tendon Repair in the Hand: A Case Study

Kelly Briody
Senior Clinician Hand Therapy.

Declaration

The author confirms that relevant local procedures were followed to obtain written and verbal consent from the patient for the publication of this case study.

Introduction

Flexor tendon injuries in the hand are common (Griffin, Hindocha, Jordan, Saleh, & Khan 2012). These injuries typically result from knife trauma, requiring surgical intervention to repair the tendon (Griffin et al 2012). Following surgical repair, timely referral to hand therapy and nursing to progress rehabilitation is required. An experienced therapist will provide intervention graded by healing tissue integrity and clinical presentation (Howell & Peck 2013). Wound management is led by nursing, requiring collaborative discussions with hand therapy on aspects of care including dressing application. A patient can typically return to unrestricted hand use by 12 weeks following surgical repair (Howell & Peck 2013). Post operation complications can occur, which prolongs the recovery and rehabilitation period. Some patients will require further surgical intervention as a result (Momeni, Grauel, & Chang 2010).

Case Report

A 48-year-old male patient sustained a knife injury to his left (L) hand. He underwent primary surgical repair of his L little finger flexor digitorum profundus (FDP) tendon, pulley venting and debulking of the flexor digitorum superficialis tendon. Post operatively he was referred to hand therapy for standard practice, early active motion and dorsal blocking splinting. The patient is employed full time as a supermarket manager. His medical history included high blood pressure.

At 2 weeks post operation, increased swelling and infection signs were observed. Wound swab results confirmed presence of infection. A course of oral antibiotics (AB) was commenced, as well as application of alginate dressing for wound management. The frequency of his home exercise program was reduced to further support wound healing.

By week 3, infection signs had settled, yet wound-gaping remained with on-going exudatinon and bleeding. Range of motion exercises were further limited to reduce pressure and tension on the wound. At this point the therapist was unable to detect L little finger FDP function yet the patient reported feeling tension on active motion.

At 3.5 weeks, infection signs had re-emerged, requiring superficial debridement, provision of oral AB and frequent dressing changes. Tendon function was undetectable on assessment and it was deemed to have either ruptured or become adherent to surrounding tissue through extrinsic tendon healing.

By 5.5 weeks, the infection had cleared and an ultrasound showed partial rupture of the FDP tendon.

The patient underwent exploratory surgery 8.5 weeks post initial operation. Surgical findings indicated tendon rupture, however direct repair was not possible. Instead a staged tendon reconstruction was required. Stage 1 of the tendon reconstruction was completed in this operation. This involved the insertion of a silicone rod in place of the ruptured tendon to keep the tendon sheath from collapsing, and a full thickness skin graft to cover volar skin deficit at the site of the previous wound infection.

Weekly hand therapy followed this procedure with a focus on wound and scar management, oedema management, and range of motion. Static progressive flexion splinting and silicone sleeves among other interventions were used to address the limits in passive flexion motion and the thick volar scar, respectively.

This therapy focus will continue for at least 12 weeks from stage 1 tendon reconstruction surgery (20.5 weeks following initial surgical procedure). This timeframe allows for maturation of soft tissue healing prior to stage 2; however, this time frame would be further lengthened if digital stiffness remained.

The second stage of tendon reconstruction requires removal of the silicone rod and the insertion of a donor tendon into the tendon sheath. The donor tendon is sutured to the remaining FDP tendon.

Hand therapy will commence following this procedure focusing on early active motion and dorsal blocking splint, similar to the first surgery post operation management. The aim of this therapy is to progress the reconstructed tendon to function. This reconstructed tendon has the potential to sustain unrestricted loading by the 12-week mark following the second stage operation (32.5 weeks from the original operation).

Discussion

This patient's post-operative care has been, and continues to be a coordinated effort between hand therapy, nursing and the specialist medical team. Open communication within the shared outpatient work space and respect for discipline-specific expertise in elevating concerns and decision-making has been pivotal.

The post operation infection and delayed wound healing has proven to be a significant complication to this patient's recovery following flexor tendon repair. The infection has likely caused the rupture, secondary to the 'one wound, one scar' principal of soft tissue healing (Peacock, 1984). The infection will have caused binding adhesion of damaged tissue to surrounding structures. This binding leads to limited excursion of the repaired tendon, and gaping or rupturing at the repair site with active motion (Peacock, 1984). This clinical situation leaves no option but a staged tendon reconstruction to restore the tendon's function. A full thickness skin graft was also required in this patient's case.

The impact of infection in this patient's rehabilitation has been significant. It has lengthened his return to unrestricted hand function by a minimum of 20 weeks. The patient has, and will undergo additional surgeries and he has been required to attend the hospital twice weekly for much of his recovery time to date. He has been unable to complete work tasks in his normal capacity.

While his rehabilitation is ongoing, the shared patient and therapist goal is to restore a functional L little finger. It is unlikely that he will regain full active motion.

Conclusion

This case highlights how infection and delayed wound healing can have a profound impact on flexor tendon repair in the hand. The cost to the patient will include a significantly lengthened time to unrestricted hand use, additional surgeries and frequent out-patient appointments, many more than when compared to uncomplicated flexor tendon rehabilitation. This complication has defined the patient journey from flexor tendon injury to recovery and redefined what recovery will look like.

References

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Peacock, EE (1984). *Wound Repair*, W. B. Saunders Co., Philadelphia.

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"Effectiveness of an internet-based learning program on venous leg ulcer nursing care in home health care - study protocol"

Ylönen M, Viljamaa J, Isoaho H, Junttila K, Leino-Kilpi H & Suhonen R *(2015) Journal of Advanced Nursing*, 71, 10, 2413-2425.
doi: 10.1111/jan.12683. Epub 2015 May 14. PMID: 25976713

Abstract

Aim: To describe the study protocol for a study of the effectiveness of an internet-based learning program on venous leg ulcer nursing care (eVLU) in home health care.

Background: The prevalence of venous leg ulcers is increasing as population age. The majority of these patients are treated in a municipal home healthcare setting. However, studies show nurses' lack of knowledge of ulcer nursing care.

Design: Quasi-experimental study with pre- and post measurements and non-equivalent intervention and comparison groups.

Methods: During the study, nurses taking care of patients with a chronic leg ulcer in home health care in one Finnish municipality will use the eVLU. Nurses working in home health care in another Finnish municipality will not use it providing standard care. Nurses will complete three questionnaires during the study and they will also be observed three times at patients' homes. Nurses' perceived and theoretical knowledge is the primary outcome of the study. Funding for this study was received from the Finnish Foundation for Nursing Education in 2014.

Discussion: Data from this study will provide information about the effectiveness of an internet-based educational program. After completing the program nurses will be accustomed to using internet-based resources that can aid them in the nursing care of patients with a VLU. Nurses will also have better knowledge of VLU nursing care.

Keywords: Education; home healthcare; internet-based education; learning; nurse; study protocol; venous leg ulcer

This study is registered with the International Clinical Trials Registry, identifier NCT02224300.

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