The Use of MEDIHONEY® for Wound Management in Oncology

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A Magnet Hospital

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Agenda

• My Clinical Practice
• Why MEDIHONEY®? What can it do?
• A Review of Cases
• Impact on My Practice
• Tips & Pointers
• Q&A
My Clinical Focus

Oncology:

• Inpatient
  – Surgical, stemcell (transplant), medical, radiation...

• Outpatient
  – 10-12 visits per day that include tumors, radiation, surgical wounds,
  – Multiple comorbidities
  – Many follow up wounds with pictures emailed, phone calls

• Staff Education
• Patient Support
MEDIHONEY®
What is it? What can it do?

• Derived from the pollen and nectar of a specific *Leptospermum Scoparium* species of plant in New Zealand

• Unique among honey – maintains its effectiveness even in the presence of wound fluid

• Shown in randomized controlled trial where the mean healing time was significantly faster for wounds treated with MEDIHONEY® impregnated dressings when compared to conventional dressings¹

• Two key mechanisms of action create an optimal environment to promote the removal of necrotic tissue and healing – High Osmolarity and Low pH

High Osmolarity

MEDIHONEY® produces an Osmotic Effect drawing fluid from deeper tissue to the wound surface.

Works with the body’s natural processes to bathe the wound and promote the removal of necrotic tissue.
Wound healing favors an acidic environment

MEDIHONEY® pH 3.5-4.5

Neutral

Chronic wounds have an elevated alkaline pH (between 7.15-8.9)

The low pH of MEDIHONEY® helps to lower the pH within the wound environment\textsuperscript{2,3}, which has been shown to have wound healing benefits.\textsuperscript{4}

Two Actions Promoting Autolytic Debridement and Healing

Baseline

- Slough, eschar, and elevated pH
- High osmotic pull bathes wound
  - Low pH impacts wound bed
  - Non-viable tissue is removed

Clean Wound Bed
Different Configurations to assist Wound Bed Preparation

- MEDIHONEY® Paste
- MEDIHONEY® Gel
- MEDIHONEY® HCS
- MEDIHONEY® Calcium Alginate
- MEDIHONEY® Honeycolloid
Case Review
Case 1 – Treating Dry and Moist Desquamation Post Radiation

DAY 1

- Stage IV reoccurrence lobular infiltrating 57 year old.
- One week post radiation, partial / full thickness tissue loss
- Pt. received radiation at home from 7/9/12-8/22/12 (33 treatments)
- Instructed to apply moisturizer to skin
- Skin painful, slightly warm to touch
- Presentation to clinic with dry & moist desquamation, erythema on 8/28/12 and Medihoney HCS initiated
Case 1 – Treating Dry and Moist Desquamation Post Radiation

DAY 1

- Initiated MEDIHONEY® HCS bordered and non-bordered
- Objective – Debride, aid healing of moist desquamation, donate moisture to area
- Used 4.5x4.5 HCS size; good size when dealing with creases
- Patient very satisfied with soothing feel on application
Case 1 – Treating Dry and Moist Desquamation Post Radiation

DAY 2

- Significant improvement overnight
- Area of moist desquamation is healing
- Dead tissue lifted away/ skin looking healthier
Case 1 – Treating Dry and Moist Desquamation Post Radiation

Summary

- Effective debridement initiated overnight
- Pt continued with Paste for Mastectomy incision (remained closed)
- Applied HCS for 3 more times until 100% resurfaced
- Learning: Water aids in gentle removal of dressings
Case 2 – Clinical Objective: Reduce Desquamation During Radiation

Day 1

- 50 yr old male with squamous cell subglottic cancer: T2N2 stage IVA.
- Long time smoker, asbestos exposure and hypertension
- Radical surgery leaving graft and flap – high risk of break down
- Starting radiation therapy – 14 treatments in total
- Began covering radiation fields with MEDIHONEY® HCS to attempt to reduce /prevent radiation dermatitis/desquamation
Case 2 — Clinical Objective: Reduce Desquamation During Radiation

Day 15

- Very minimal inflammatory response observed
- Incision line remains intact
- Continued use of MEDIHONEY®
Case 2 – Clinical Objective: Reduce Desquamation During Radiation

Day 26

- Erythema and hyperpigmentation observed
- No dry desquamation
Case 2 – Clinical Objective: Reduce Desquamation During Radiation

Day 34

- Dry desquamation.
- Upon dressing removal - dead skin lifting away with health skin underneath
- No moist desquamation noted
- Learning: Water aids dressing removal / instruct patient to remove in shower
Case 2 – Clinical Objective: Reduce Desquamation During Radiation

Summary

- No moist desquamation ever developed
- Reduced inflammatory response observed
- Met clinical objective
Case 3 – Dehisced Surgical Wound, Breast Cancer Patient

DAY 1

39 y/o female recurrent (2007) Stage IV metastatic breast cancer
Chemo and radiation followed by a myocutaneous flap surgery harvested from the abdomen to reconstruct her chest wall in August 2012
Abdominal wound with surgical mesh implant with poor healing
Readmitted for dehiscence October 2012
Initiated MEDIHONEY® Gel (applied to non-adherent) and NPWT
Case 3 – Dehisced Surgical Wound, Breast Cancer Patient

**DAY 12**

- Mesh no longer visible due to granulation tissue growth, only slight amount of slough remains.
- Continued MEDIHONEY® / VAC treatment with steady progress

**DAY 27**

- Complete debridement
- Significant wound size reduction and wound edge advancement
Case 3 – Dehisced Surgical Wound, Breast Cancer Patient

DAY 37

- Further advancement
- Patient was ready for surgical closure
Case 3 – Dehisced Surgical Wound, Breast Cancer Patient

Summary

• Steady debridement and healing over 37 days
• Patient able to get back on curative treatment 4 weeks post surgical closure
Case 4 – Re-occurrence, Basal Cell Carcinoma with Squamous Differentiation

51 yr old male with history of basal cell carcinoma with squamous differentiation

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>2007</td>
<td>MOHS surgical procedure - clear margins</td>
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<tr>
<td>2010</td>
<td>Reoccurrence with orbital cellulitis. Treatment: Eviredge</td>
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<tr>
<td>2012</td>
<td>Mass in left cavernous sinus infiltrate into left orbital – did not excise only biopsied. 33 treatments of Radiation</td>
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<tr>
<td>2013</td>
<td>December follow-up MRI shows significant worsening of the left scalp mass involving the left frontal skull, left face, left orbit, left masticator space and cavernous sinus</td>
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<td>2014</td>
<td>January Everidge discontinued. Patient was started on Carboplatin/Taxol. February - Came to Midwestern Region Medical Center for second opinion. Everidge restarted and carbo DC after review of new scans</td>
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Case 4 – Re-occurrence, Basal Cell Carcinoma with Squamous Differentiation

• Patient presentation - pink, granulating wound base / attached thin .5cm bridge between wound and socket, some scattered slough
• Initiated MEDIHONEY® Paste on non-adherent.
• Genome sequencing results revealed 9 driver mutations.
• Erbitux 500mg q 2 wks, develop typical skin response to meds
• Progress of tumor slowed and wound cleaned up well with MEDIHONEY®
Case 4 – Re-occurrence, Basal Cell Carcinoma with Squamous Differentiation

July 2014

• Pt returned with new lesion. 40% necrotic tissue, yellow drainage
• Biopsy confirmed disease progression
• Initiated MEDIHONEY® gel (thicker than Paste) impregnated onto mesh to promote debridement
• Erbitux stopped. Patient consented to new agent (AFATINIB 40mg q daily – 3wks for insurance approval), to try to halt disease progression.

Wound measurement (cm): 3.5 L x 4W x .1D
Case 4 – Re-occurrence, Basal Cell Carcinoma with Squamous Differentiation

September 2014

- Effective debridement of slough
- Scattered necrotic tissue remains, tunnels 6cm, drainage pooling
- Patient now able to self irrigate and pack wound
  - Irrigation - MEDIHONEY® Paste and warm water
  - Packing – Pt. gently “paints” MEDIHONEY® onto wound base and packs with alginate for extra absorption

Wound Pocket measurement (cm): 2.5 L x 2W x 3D
Case 4 – Re-occurrence, Basal Cell Carcinoma with Squamous Differentiation

Summary of Debridement

- Challenging second lesion was gently debrided with MEDIHONEY®
- Pt. battling fatigue (mental and emotional) but able to continue curative treatment
Case 5 – Metastatic Lower Lumbar Tumor

- 46 year old female, history of metastatic triple negative left breast cancer
- Multiple bone, bilateral adrenal lumbar and mediastinal metastases
- Painful, oozing wound around protruding lumbar tumor
- MEDIHONEY® HCS initiated. Patient reported pain going from 10 to 2.
Case 6 – Various Tumors and Wound Management

- Many Tumors do not debride well, bleed easily, are fragile, odorous
- MEDIHONEY® provides gentle yet rapid, autolytic debridement of odorous slough tissue
- Pts have reported greater comfort, reduced odor as slough is removed
- Natural alternative that is cost effective yet safe and accessible
Impact of MEDIHONEY® to Practice

During radiation/weekend use:
- Potential to prevent or ease inflammatory response
- Osmotic Effect – ability to draw moisture to area

Post radiation:
- Healing: dry and moist desquamation
- Patient Comfort

Wound Management:
- Debridement, healing – Get patients back on plan
- Stabilize wounds (Hospice patients)
- Patient comfort

Cost effective medical dressing/ Patient ease of access - available through DME/HCPCS for reimbursement
TIPS & Pointers

- HCS dressing for Rad. Desquamation during and post treatment
- Tip: Skin heat may cause HCS difficulty adhering – Use MEDIHONEY® Gel & non-adherent
- Tip: Water aids removal - makes HCS dressing slippery and fall off

- Gel is smooth “toothpaste” consistency – comfortable for sensitive areas (genitalia)

- Paste for wounds in the mouth, on face, sinus tract

- Impregnated Calcium Alginate for deeper wounds, multi-day use
- Tip: May help reduce dressing changes
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Questions?

Event Resources

Click to download resources now:
- Today’s Slides
- MEDIHONEY® Wound Protocol Guide
- MEDIHONEY® FAQs
- MEDIHONEY® Quality Fact Sheet
- Product Codes Listing

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