Make a clear choice.

Use our T.I.M.E.[1,2] clinical decision support tool and proven portfolio to choose the right product, for the right wound, at the right time.

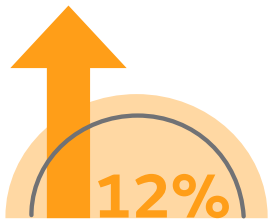
Smith+Nephew

1. Schultz GS, Sibbald RG, Falanga V, *et al.* Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19.

Contents

1. Meeting unmet needs

A system under pressure



Chronic wounds

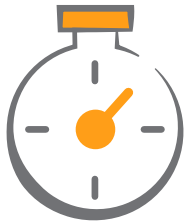
It is estimated that the prevalence of chronic wounds is **growing at 12% per year**[1]

Huge inconsistency in practice[2]

Many clinical pathways are complex and hard to navigate, with no clear and consistent tools to implement in practice

Spiralling costs

When wounds don't heal, costs spiral[1] - but the cost to patients' lives can be even greater



Time is precious

Nurses are expected to do more and more in less time – sometimes treating wounds can seem like a losing battle

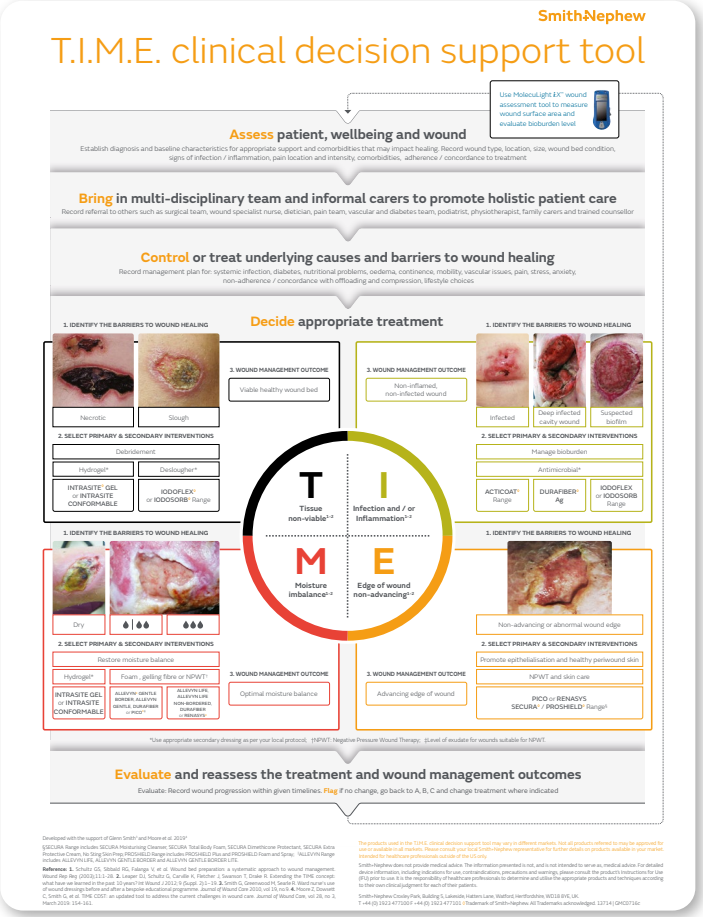
Your decisions matter

That's why we've worked with clinicians to develop simple tools to help you identify problems quickly and to help you know when to refer – helping to give you the confidence to make the right treatment choices.

1. Guest, *et al*. The health economic burden that acute and chronic wounds impose on an average clinical commissioning group/health board in the UK. *JWC*. 2017; 26(6):292-303. **2.** Ousey K, Gilchrist B, Jaimes H. Understanding clinical practice challenges: a survey performed with wound care clinicians to explore wound assessment frameworks. *Wounds International*. 2018;9(4):58-62.

2. Introducing T.I.M.E.[1,2] clinical decision support tool*

Five-step framework to help achieve simplification and systematic consistency in practice



Assess patient, wellbeing and wound

The tool begins by assessing the patient. It is important that the healthcare professional takes a holistic view of the patient's wellbeing, which the tool takes into account.

Bring in multi-disciplinary team and informal carers to promote holistic patient care

The healthcare professional must consider whether they are able to treat the patient and refer, if necessary, before they proceed. Carers need to be involved.

Control or treat causes and barriers to wound healing

Viewing patient wellbeing as a whole is built into the tool. Therefore, the healthcare professional must consider other underlying issues as well.

Decide appropriate treatment

The assessment of the wound should be carried out following the well-established T.I.M.E. principles.

Evaluation and reassessment of treatment and wound management outcomes

It is key that this step is carried out consistently and regularly to ensure wound progression.

Return to A, B, C, D if wound did not progress.

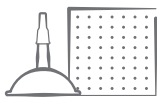
*Developed with the support of Glenn Smith[3] and Moore et al. 2019[4]

1. Schultz GS, Sibbald RG, Falanga V, *et al.* Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19. **3.** Smith G, Greenwood M, Searle R. Ward nurses' use of wound dressings before and after a bespoke educational programme. *Journal of Wound Care,* Vol. 19., no. 9, Sept 2010. **4.** Moore Z, Dowsett C, Smith G, *et al.* TIME CDST: an updated tool to address the current challenges in wound care. *Journal of Wound Care*, Vol 28, no 3, March 2019: 154-161.

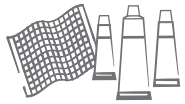
3. Decide appropriate treatment with our T.I.M.E.[1,2] portfolio

Our comprehensive, synergistic portfolio has been designed to address unique wound needs: removing non-viable tissue, managing bioburden and exudate to managing non-advancing or abnormal wound edges.

Use MolecuLight *i:X*™ wound assessment tool to measure wound surface area and evaluate bioburden level



INTRASITE◊ GEL or INTRASITE CONFORMABLE



IODOFLEX◊ or IODOSORB◊ Range

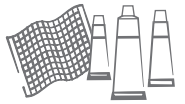
T Tissue non-viable[1-2]

I Infection and / or inflammation[1-2]

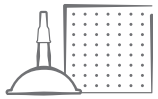
Identify the barriers to wound healing

ACTICOAT◊ Range

DURAFIBER◊ Ag Dressing



IODOFLEX or IODOSORB Range



INTRASITE GEL or INTRASITE CONFORMABLE

ALLEVYN◊ LIFE or ALLEVYN GENTLE BORDER Dressings

RENASYS◊ or PICO◊ NPWT*

M Moisture imbalance[1-2]

E Edge of wound non-advancing[1-2]

Identify the barriers to wound healing

PICO or RENASYS NPWT PROSHIELD◊ Range†

*Level of exudate for wounds suitable for NPWT. †PROSHIELD Range includes PROSHIELD Foam & Spray and PROSHIELD Plus Skin Protectant.

1. Schultz GS, Sibbald RG, Falanga V, *et al.* Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19.

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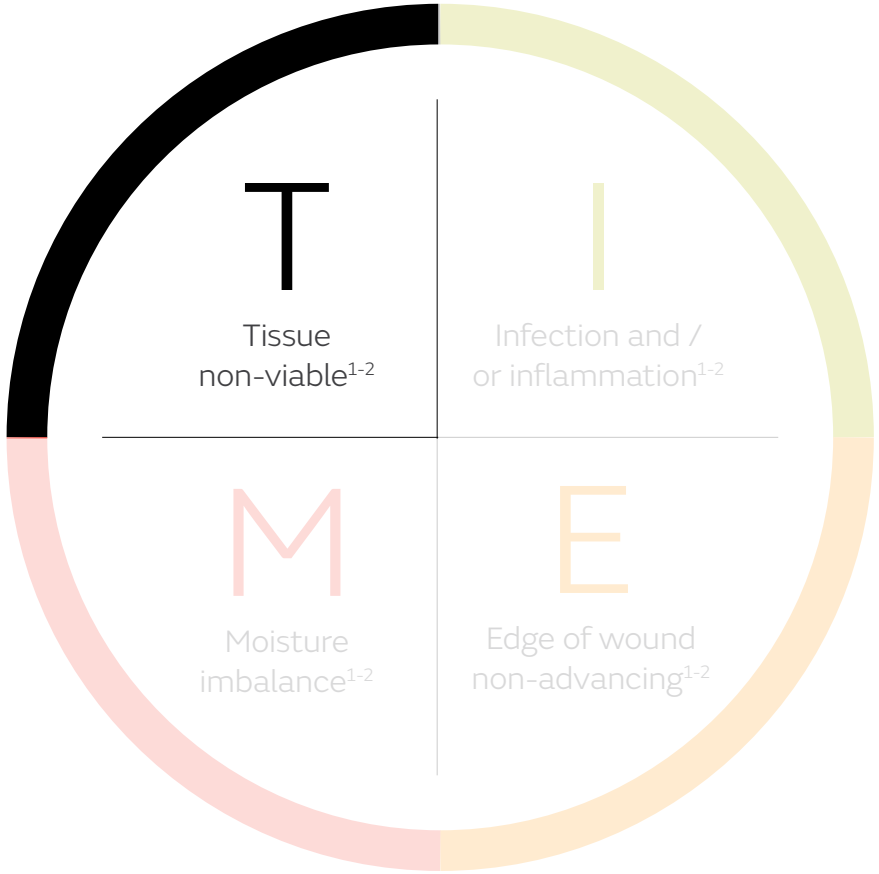
4. T ✚ the S+N portfolio

Quick reminder of T (non-viable tissue) in T.I.M.E.[1,2]

CLINICAL OBSERVATIONS
Tissue non-viable
PATHOPHYSIOLOGY
Defective matrix and cell debris impair healing
WOUND BED PREPARATION (WBP) CLINICAL ACTIONS
Debridement (episodic or continuous): autolytic, sharp surgical, enzymatic, mechanical, hydro surgical or biological
EFFECT OF WBP ACTIONS
Restoration of wound bed
CLINICAL OUTCOMES
Viable healthy wound bed



1. Schultz GS, Sibbald RG, Falanga V, *et al.* Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19.

4. T ✚ the S+N portfolio

Understanding your needs

Wounds will not progress unless debridement is successfully completed[1,3]

Resources and time are being wasted when advanced dressings/ therapies are placed on a non-prepared wound bed

Debridement of non-viable material is key to achieve a viable wound bed[1]

The methods, skills and resources to manage the debridement process vary greatly[2]

Failure to select the most appropriate method has consequences[3]

Potential delays in wound healing, increased costs and unnecessary patient suffering[3]

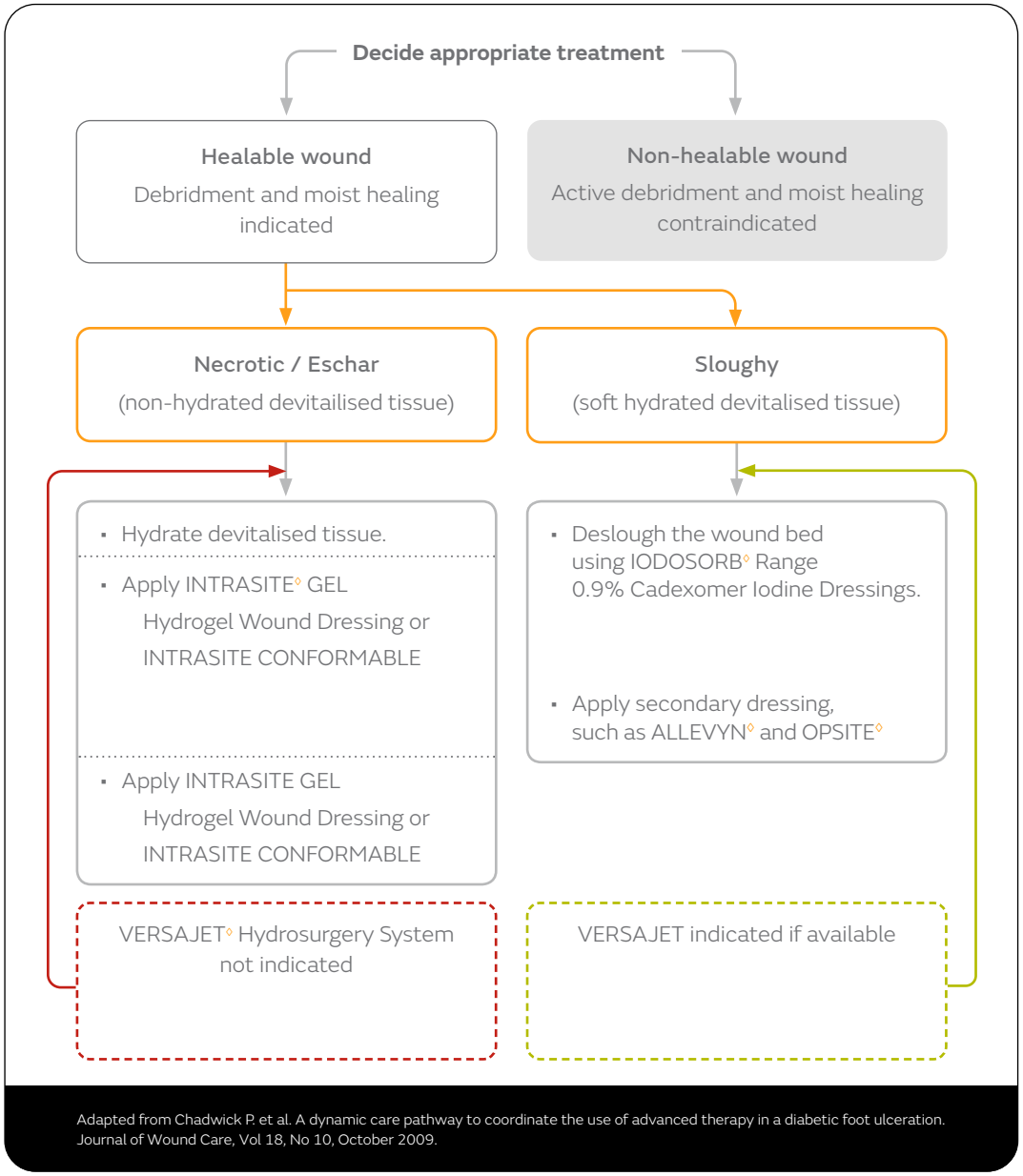
1. Tallis A, *et al*. Clinical and economic assessment of diabetic foot ulcer debridement with collagenase: Results of a randomized controlled study. *Clinical Therapeutics*/Volume 35, 11 (2013). **2.** Milne CT, *et al*. A comparison of collagenase to hydrogel dressings in wound debridement. *Wounds* 22 (11):270–274 (2010). **3.** Atkin L. A guide to wound debridement. http://www.independentnurse.co.uk/clinical-article/a-guide-to-wound-debridement/114500 (2016).

4. The clear choice:

a pathway to guide appropriate treatment for non-viable tissue

Wound debridement should be an integral element of good wound care. By integrating a clear pathway, optimal debridement that is tailored to the individual and their wound can be delivered.

Use MolecuLight *i*:X™ to evaluate bioburden level



Adapted from Chadwick P. et al. A dynamic care pathway to coordinate the use of advanced therapy in a diabetic foot ulceration. Journal of Wound Care, Vol 18, No 10, October 2009.

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5. I ✚ the S+N portfolio

Quick reminder of I (infection and/or inflammation) in T.I.M.E.[1,2]

CLINICAL OBSERVATIONS

Infection and/or inflammation

PATHOPHYSIOLOGY

High bacterial counts or prolonged inflammation:
+ Inflammatory cytokines
+ Protease activity
- Growth factor activity

WOUND BED PREPARATION (WBP) CLINICAL ACTIONS

Remove infected foci topical/systemic:
- Antimicrobials
- Anti-inflammatories
- Protease inhibition

EFFECT OF WBP ACTIONS

Low bacterial counts or reduced inflammation:
- Inflammatory cytokines
- Protease activity
+ Growth factor activity

CLINICAL OUTCOMES

Non-inflamed, non-infected wound

1. Schultz GS, Sibbald RG, Falanga V, *et al.* Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19.

5. I ✚ the S+N portfolio

Understanding your needs

30% of venous leg ulcer (VLU) patients have a wound at risk of infection or are clinically infected[1]

The cost of managing these VLU patients is estimated to be a mean £13,224 per patient[1]

Diabetic foot ulcer (DFU) infection not only delays wound healing but also may lead to amputation in 17% of cases[2]

The cost of treating an unhealed DFU is estimated to be £8,800, with the added complication of amputation costing up to £16,900 per amputated wound[2]

Up to 80% of chronic wounds contain biofilm[3]. Biofilm is present in most, if not all, chronic non-healing wounds[4]

Biofilms substantially delay wound healing[5-7] and cause recurrent infections,[8] antimicrobial treatment failure[9-11] and low-level inflammation and tissue damage[8,12]

Patient quality of life is affected by infected chronic wounds[13]

Infected wounds have an impact on stress and anxiety levels for the patient[13]

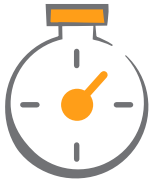
1. Guest JF. Costs and consequences of managing infection associated with venous leg ulcers in the UK. Presentation. CATALYST Health Economics Consultants Ltd Northwood, Middlesex, UK. in (2017). **2.** Guest JF, Fuller GW, Vowden P. Diabetic foot ulcer management in clinical practice in the UK: costs and outcomes. *Int Wound J* 15, 43–52 (2018). **3.** Malone M, *et al.* The prevalence of biofilms in chronic wounds: a systematic review and meta-analysis of published data. *J Wound Care* 26, 20–25 (2017). **4.** Schultz G, *et al.* Consensus guidelines for the identification and treatment of biofilms in chronic nonhealing wounds. *Wound Repair Regen.* 25, 744–757 (2017). **5.** Schierle CF, De la Garza M, Mustoe TA, Galiano RD. *Staphylococcal* biofilms impair wound healing by delaying reepithelialization in a murine cutaneous wound model. *Wound Repair Regen.* 17, 354–9 (2009). **6.** Roche ED, *et al.* Increasing the presence of biofilm and healing delay in a porcine model of MRSA-infected wounds. *Wound Repair Regen.* 20, 537–43 (2012). **7.** Zhao G, *et al.* Time course study of delayed wound healing in a biofilm-challenged diabetic mouse model. *Wound Repair Regen* 20, 342–352 (2012). **8.** Costerton JW, Stewart PS, Greenberg EP. Bacterial biofilms: a common cause of persistent infections. *Science* 284, 1318–22 (1999). **9.** Stewart PS, Costerton JW. Antibiotic resistance of bacteria in biofilms. *Lancet* 358, 135–8 (2001). **10.** Stewart PS, Rayner J, Roe F, Rees WM. Biofilm penetration and disinfection efficacy of alkaline hypochlorite and chlorosulfamates. *J. Appl. Microbiol.* 91, 525–32 (2001). **11.** Phillips PL, *et al.* Antimicrobial dressing efficacy against mature *Pseudomonas aeruginosa* biofilm on porcine skin explants. *Int. Wound J.* 12, 469–83 (2013). **12.** Bjarnsholt T, *et al.* Why chronic wounds will not heal: a novel hypothesis. *Wound Repair Regen.* 16, 2–10 (2008). **13.** Upton D, Solowiej K. Pain and stress as contributors to delayed wound healing. *Wound Pract. Res.* 18, 114–122 (2010).

5. The clear choice

A pathway to guide appropriate treatment for local infection and biofilm

The potential opportunities associated with adopting a clear pathway with early intervention to address obvious clinical infection or biofilm are:

1.



Reduce the length of time patients are suffering with their infected wound,[1-4] freeing up valuable nurse resource to manage their increasing workload

2.

Reduce the volume of antimicrobial dressings used, which in turn could reduce your expenditure within this category[5]

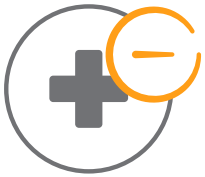
3.

Enhance the quality of care provided by your community teams, upskill their knowledge and help ensure appropriate use of advanced wound dressings

4.

Minimise the progression of local wound infection to more severe infection[4]

5.



Reduce the cycle of treatment failure and recurrent infections

1. Schultz G, *et al.* Consensus guidelines for the identification and treatment of biofilms in chronic nonhealing wounds. *Wound Repair Regen.* 25, 744–757 (2017). **2.** Guest JF, Fuller GW, Vowden P. Venous leg ulcer management in clinical practice in the UK: costs and outcomes. *Int Wound J* .15, 29–37 (2018). **3.** Dowsett C, Bielby A, Searle R. Reconciling increasing wound care demands with available resources. *J. Wound Care* 23, 552, 554, 556–8 passim (2014). **4.** Newton H. Reducing MRSA bacteraemias associated with wounds. *Wounds UK* 6, 56–65 (2010). **5.** Searle R, Bielby A. Dressing strategies for the management of infected wounds in community wound care: impacts and implications. *Wounds UK* (2010).

5. The clear choice

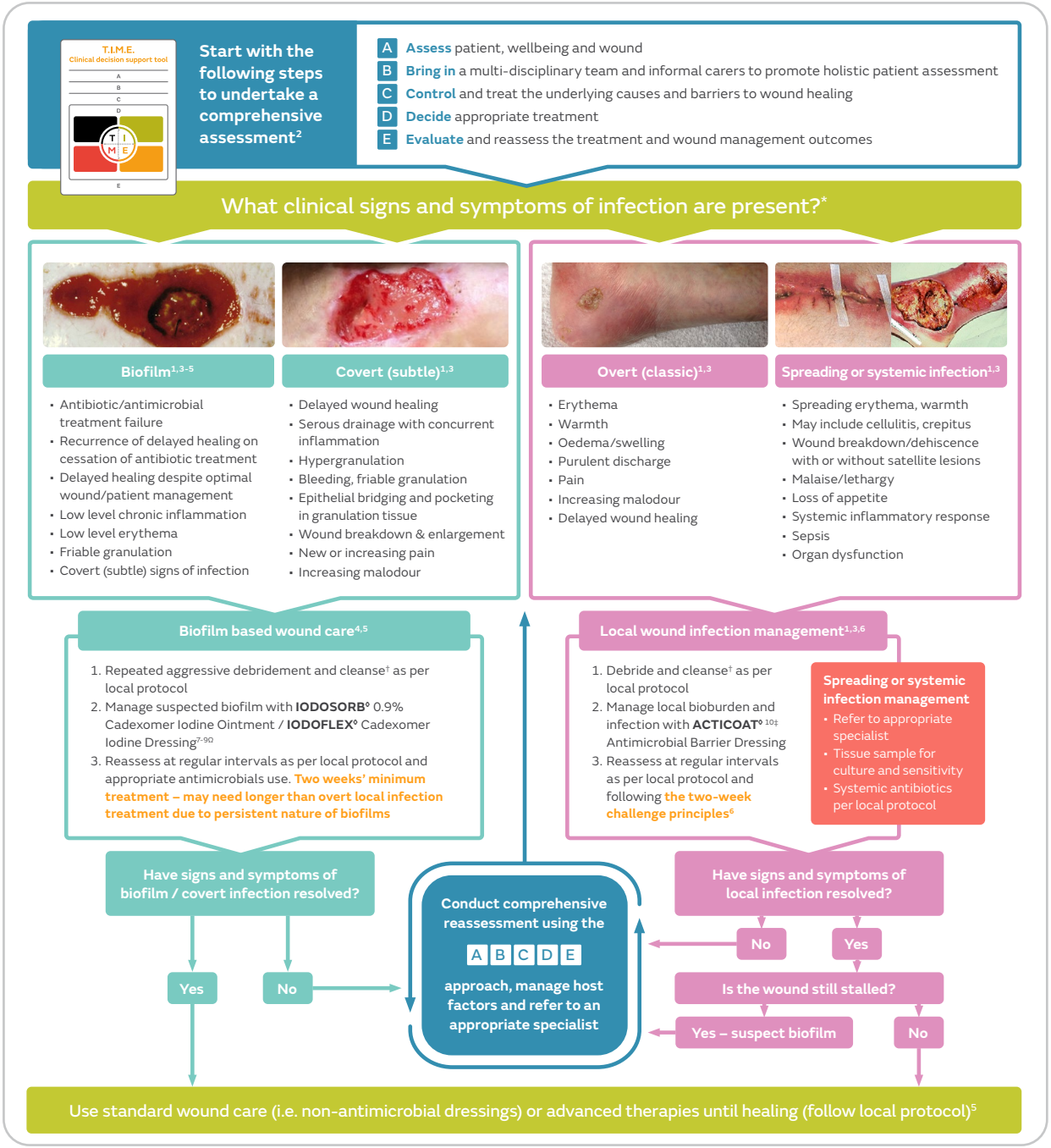
A route to more effective infection management

The Infection management pathway

We'd like to show you the infection management pathway in more detail.

Please click on the button below and see for yourself how simple and effective decision making can make all the difference.

Consider the use of DURAFIBER◊ Ag Silver Gelling Fibre Dressing for deep infected wounds



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6. M ✚ the S+N portfolio

Quick reminder of M (moisture imbalance) in T.I.M.E.[1,2]

CLINICAL OBSERVATIONS
Moisture imbalance
PATHOPHYSIOLOGY
Dessication slows epithelial cell migration Excessive fluid causes maceration of wound margin
WOUND BED PREPARATION (WBP) CLINICAL ACTIONS
Apply moisture balancing dressings Compression, negative pressure or other methods of removing fluid
EFFECT OF WBP ACTIONS
Restored epithelial cell migration, dessication avoided Edema, excessive fluid controlled, maceration avoided
CLINICAL OUTCOMES
Optimise moisture balance

1. Schultz GS, Sibbald RG, Falanga V, *et al.* Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19.

6. M ✚ the S+N portfolio

Understanding your needs

“

Managing chronic wounds uses significantly more resources per patient, when compared to acute wounds[1]

Over 2.5x as many nurse visits[1]

“

Almost 70% of dressing changes are driven by schedules[2]

Dressing changes may dominate your patient visit, giving you less time to care for other patient needs[3]

“

Up to 50% of dressing changes in the community may be clinically unnecessary[3]

Clinically unnecesary dressing changes have a major impact on resources, schedules and costs[3]

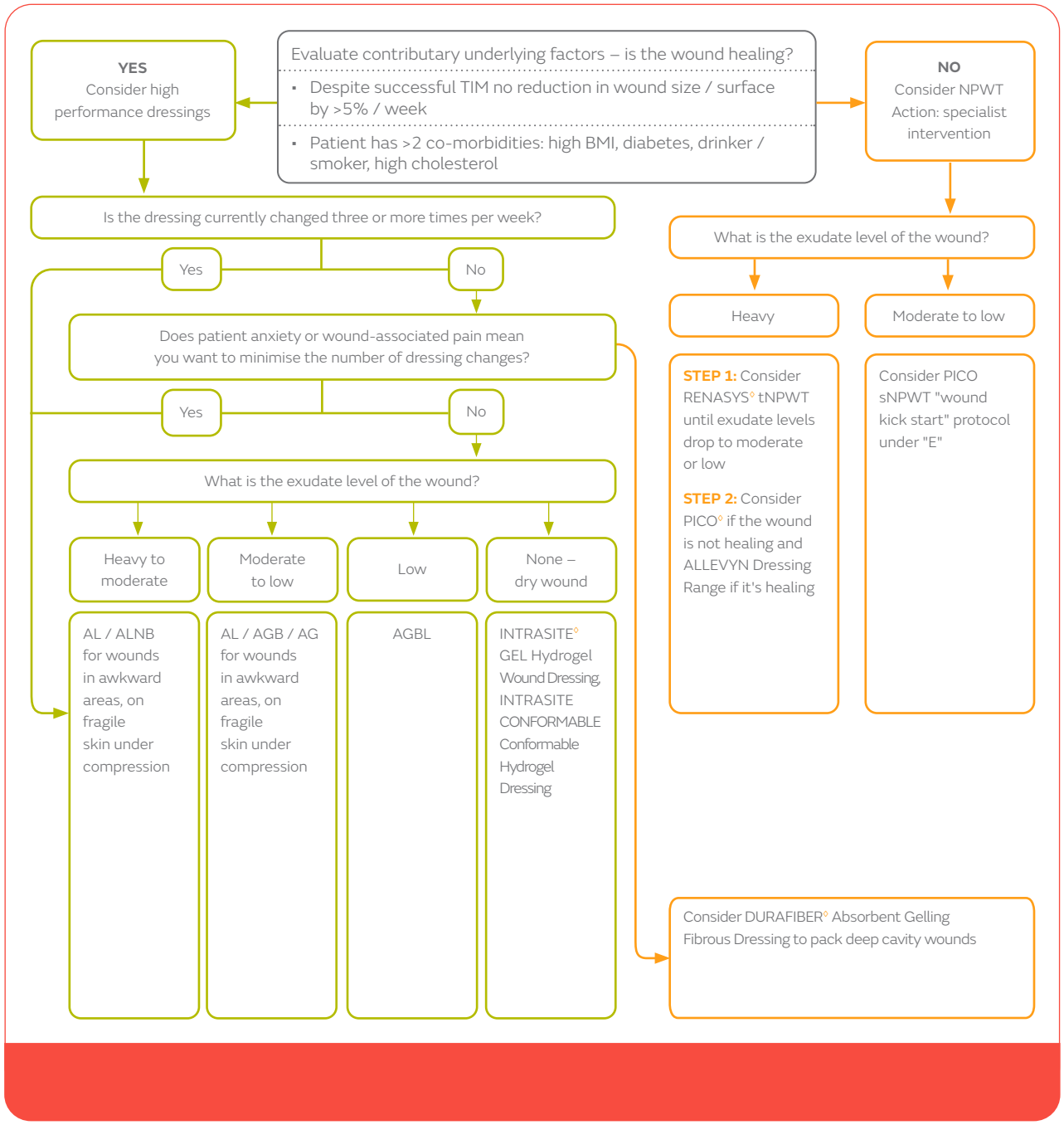
1. Guest JF, Vowden K, Vowden P. The health economic burden that acute and chronic wounds impose on an average clinical commissioning group/health board in the UK. *J Wound Care*. 2017 Jun 2;26(6):292-303. **2.** Smith+Nephew Wound Management clinical report UKI-CP-PDTK-2013-DCF/RFC-1-5-14 May 2014. In-practice dressing change frequencies and reason for dressing change 2013. Community Practice Development Tool Kit (PDTK) survey data analysis. **3.** Joy H, Bielby A, Searle R. A collaborative project to enhance efficiency through dressing change practice. *Journal of wound care*. 2015;24(7):312, 314-317.

6. The clear choice

A pathway to guide appropriate treatment for exudate management in chronic wounds

Abbreviations key:

AL: ALLEVYN◊ LIFE
ALNB: ALLEVYN LIFE NON BORDERED
AG: ALLEVYN GENTLE
AGB: ALLEVYN GENTLE BORDER
AGBL: ALLEVYN GENTLE BORDER LITE
Wound Dressings



Clinical learnings adapted from: Dowsett C, *et al.* Use of PICO to improve clinical and economic outcomes in hard-to-heal wounds. *Wounds International* (2017) Vol 8 (No. 2): 53-58.

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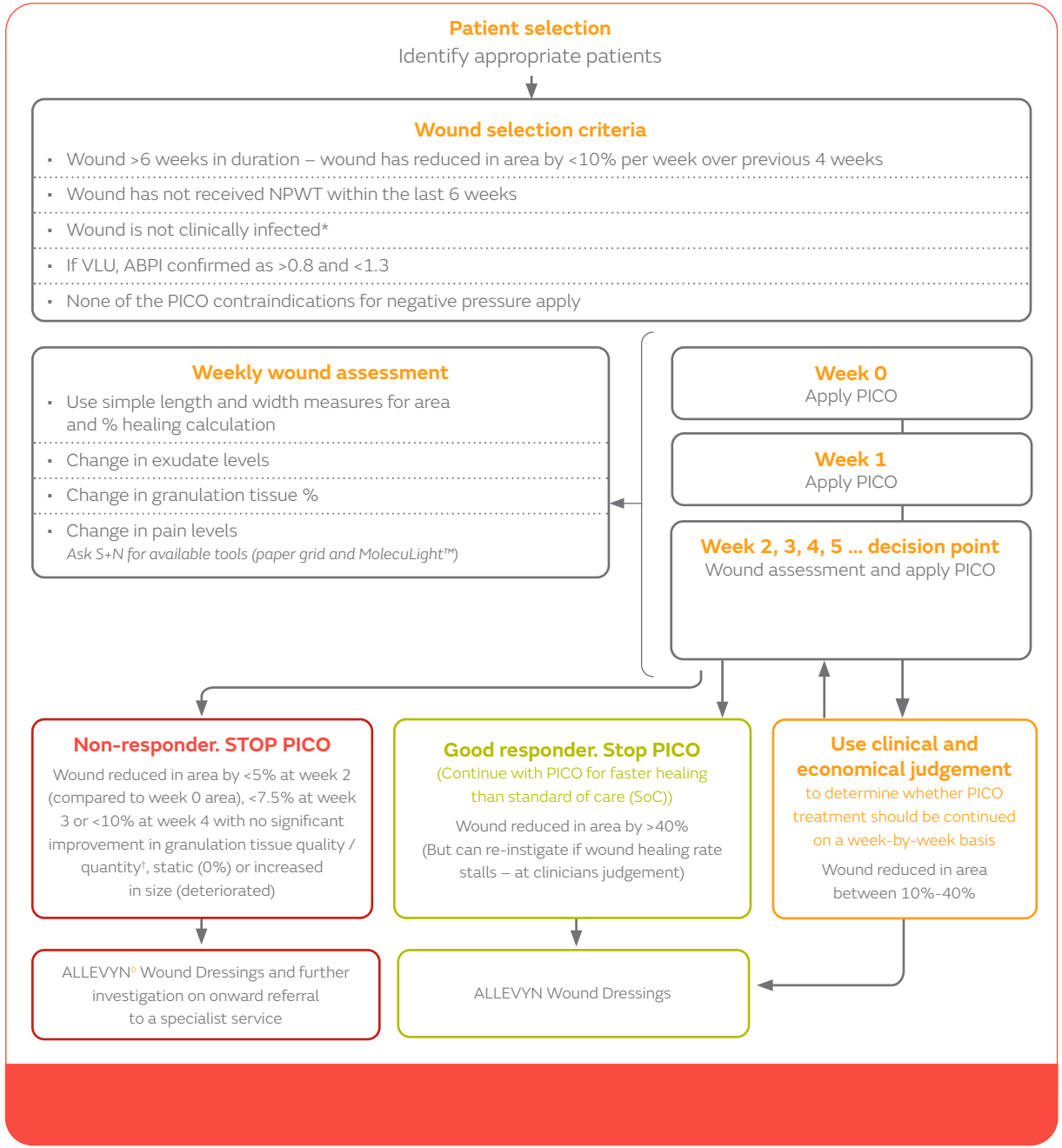
PICO◊ Single Use Negative Pressure Wound Therapy System (sNPWT) pathway

How to use the PICO System effectively and what to expect



Based on ref. 19, Figure 2: PICO pathway
*Wounds with overt signs of clinical infection (e.g. increased pain, levels of exudate, cellulitis etc.) should be excluded from the evaluation. Colonised/ critically colonised wounds are not excluded from the evaluation. Site standard protocol should be implemented to address bacterial burden; †Wounds that have healed by <10% but have shown significant improvement in granulation tissue quality/ quantity may be considered for further PICO treatment based on clinician judgement.
ABPI: Ankle–brachial pressure index
VLU: Venous leg ulcers

Dowsett C, Hampton J, Myers D, Styche T. Use of PICO to improve clinical and economic outcomes in hard-to-heal wounds. *Wounds International* (2017) Vol 8 (No. 2): 53-58.

7. E ✚ the S+N portfolio

Quick reminder of E (edge of wound non-advancing) in T.I.M.E.[1,2]

CLINICAL OBSERVATIONS

Non-advancing or abnormal wound edge

PATHOPHYSIOLOGY

Non-migrating keratinocytes

Non-responsive wound cells and abnormalities in protease activity

WOUND BED PREPARATION (WBP) CLINICAL ACTIONS

Reassess cause or consider corrective therapies:
- Debridement
- Skin grafts
- Biological agents
- Adjunctive therapies

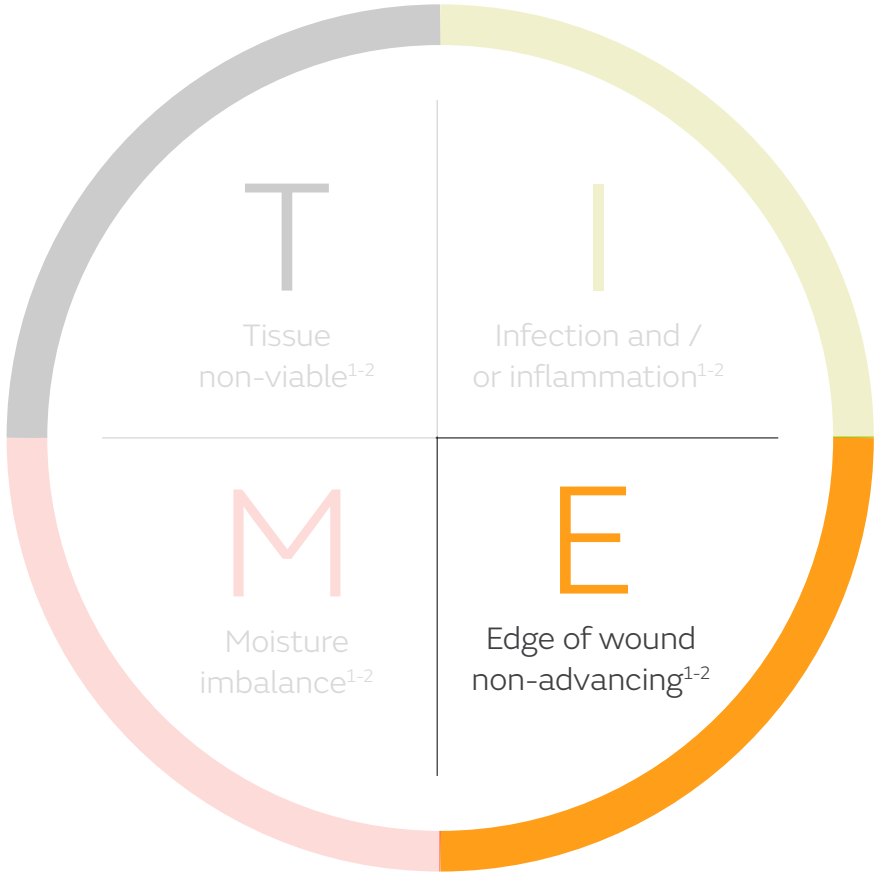
EFFECT OF WBP ACTIONS

Migrating keratinocytes and responsive wound cells

Restoration of appropriate protease profile

CLINICAL OUTCOMES

Advancing wound edge



1. Schultz G, Sibbald G, Falanga V, Ayello E, Dowsett C, Harding K, Romanelli M, Stacey M, Teot L, Vanscheidt W. Wound bed preparation: a systematic approach to wound management. *Wound Repair and Regeneration*. Vol. 11, No. 2, Supplement March–April 2003. S1-S28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19.

7. E ✚ the S+N portfolio

Understanding your needs

70–80% of wounds are treated by community nurses[1]

64% of wounds treated in home care are chronic[1]

18% of chronic wounds persist for longer than one year[3]

Patient care costs of unhealed wound is 135% more than that of a healed wound[2]

More than 60% of community nurse time is spent on dressing changes[1]

Dressing changes may dominate your patient visit, giving you less time to care for other patient needs[4]

Community nurse numbers have dropped by 39%[5]

40% of staff working in community report work-related stress[6]

1. Lindholm C, Searle R. Wound management for the 21st century: combining effectiveness and efficiency. *Int Wound J.* 2016;13 (Suppl 2):5–15. **2.** Guest JF, Vowden K, Vowden P. The health economic burden that acute and chronic wounds impose on an average clinical commissioning group/health board in the UK. *J Wound Care.* 2017;26:292–303. **3.** Ousey K, Stephenson J, Barrett S, *et al.* Wound care in five English NHS Trusts: results of a survey. *Wounds UK.* 2013;9:20–28. **4.** Joy H, Bielby A, Searle R. A collaborative project to enhance efficiency through dressing change practice. *Journal of wound care.* 2015;24(7):312, 314-317. **5.** Dowsett C, Bielby A, Searle R. Reconciling increasing wound care demands with available resources. *J Wound Care.* 2014;23:552, 554, 556–8. **6.** Leeds Community Healthcare NHS Trust RY6, Community Health Services for adult's quality report. May 2016.

7. E ✚ the S+N portfolio

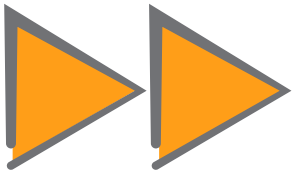
How could you make an impact on stalled wounds?

Kick-start wound healing

64% of wounds treated in home care are chronic

Identify wounds not progressing on time and change treatment to kick-start the healing process.

Did you know that 64% of wounds treated in home care are chronic?[1] These patients also have an increased risk of infections and readmissions to hospital.



Accelerate healing, achieve faster healing or increase healing rate

9 months is the average duration of a wound

Did you know that the average duration of wounds is nine months?[2] The earlier a wound heals, the less resources it will consume – but watch out, as not all single use negative pressure wound therapy (sNPWT) devices have documented clinical evidence.

Prevent stalled wounds from happening

24% of patients have been living with their wound for six months or more[1]

and almost 16% for a year or more[1] – this should change.

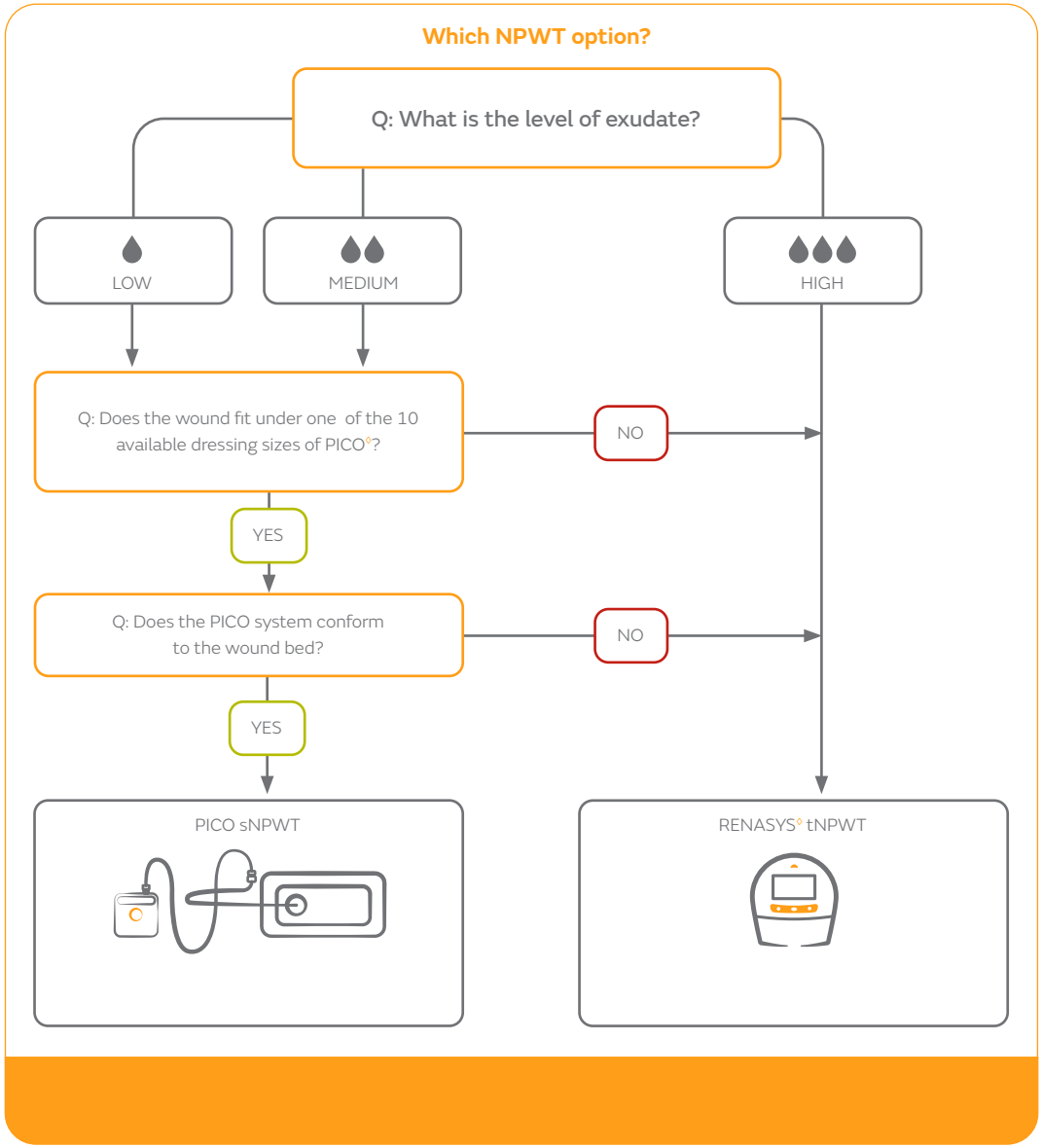
1. Lindholm C, Searle RJ. Wound management for the 21st century: combining effectiveness and efficiency. *Int Wound J.* 2016;13 Suppl 2:5–15.15. **2.** Jørgensen SF, Nygaard R, Posnett J. Meeting the challenges of wound care in Danish home care. *J Wound Care.* 2013;22:540–2, 544–545.

7. The clear choice

A pathway to guide appropriate treatment for non-advancing or abnormal wound edges

When the wound is not progressing as desired with ALLEVYN◊ Wound Dressings, consider the use of NPWT to kick-start healing on stalled wounds.

Use the PROSHIELD◊ Range for management of moisture related skin damage[1-3]



The products used in the T.I.M.E.[1,2] clinical decision support tool may vary in different markets. Not all products referred to may be approved for use or available in all markets. Please consult your local Smith+Nephew representative for further details on products available in your market. Intended for healthcare professionals outside of the US only.

1. Ling L. PROSHIELD Skin Care protective system: A sequence of evaluations. Gloucestershire NHS, UK. Presented at *Wounds UK*, 2011. **2.** Maxwell J, Sinclair D. Treatment of moisture related lesions in children. Great Ormond St Hospital for Children NHS Foundation Trust, London UK. Poster presented at EWMA 2012, Vienna, Austria. **3.** Meuleneire F. A new solution in the treatment of moisture lesions. AZ St Elisabeth Zottegem, Belgium. Presented at EPUAP 2010.

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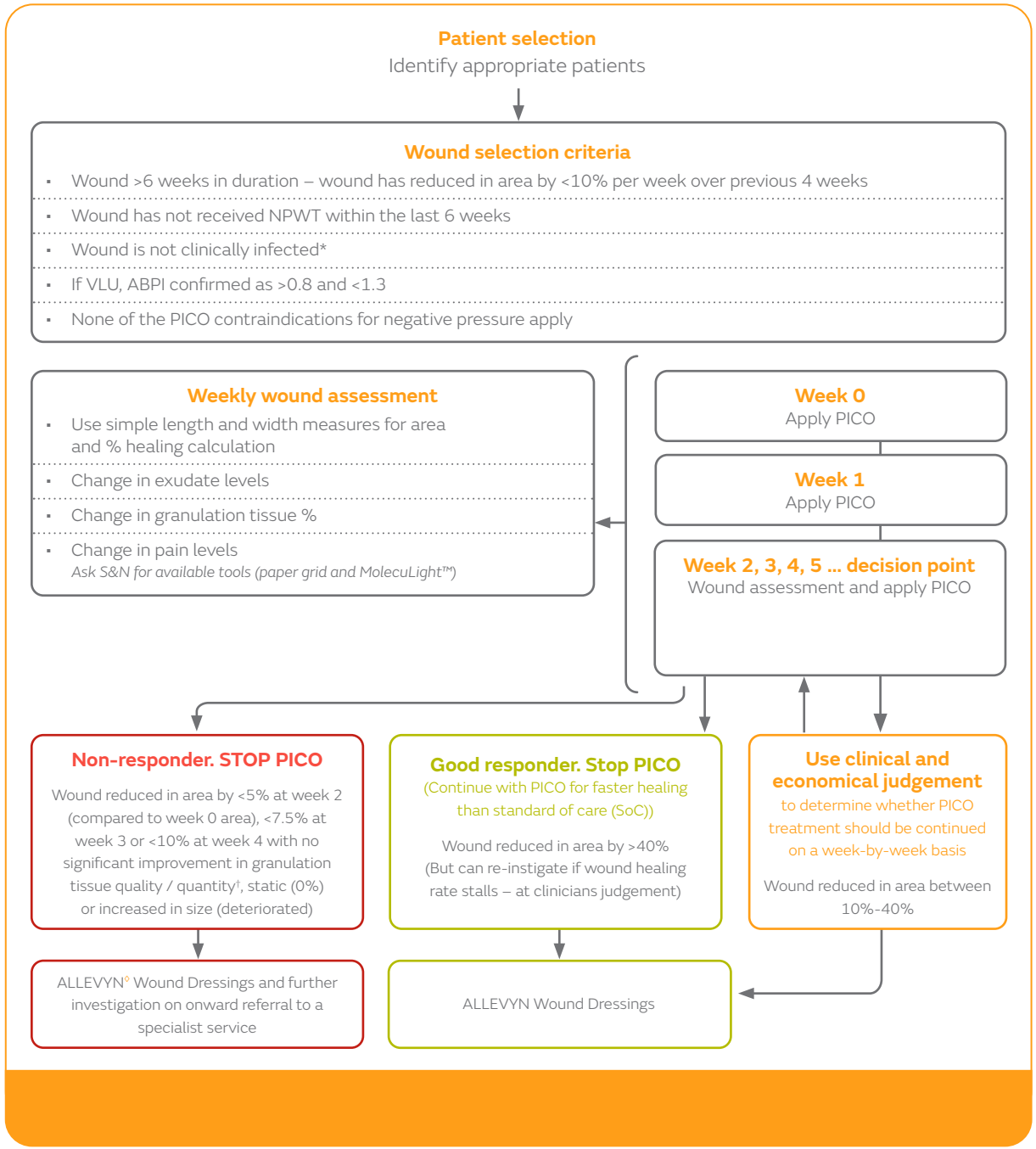
PICO◊ Single Use Negative Pressure Wound Therapy System (sNPWT) pathway

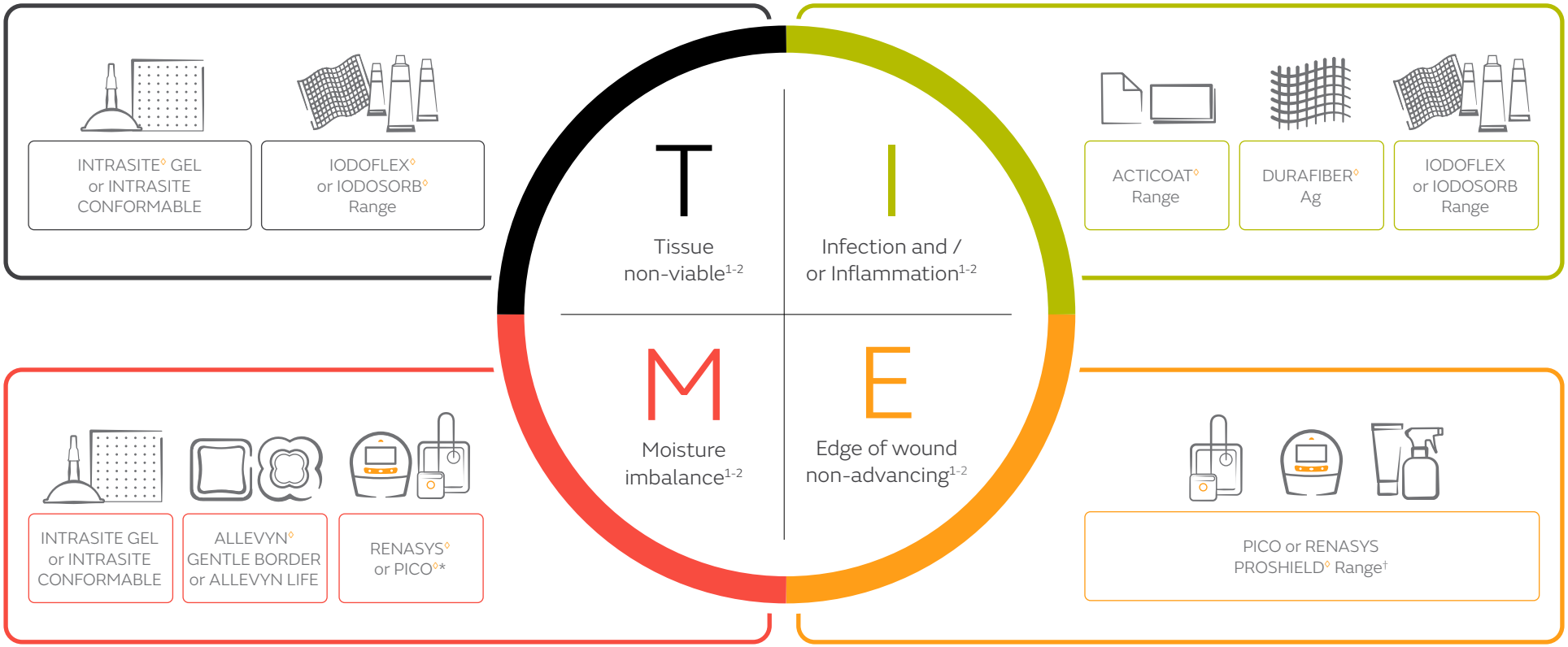
How to use PICO System effectively and what to expect



Based on ref. 19, Figure 2: PICO pathway
*Wounds with overt signs of clinical infection (e.g. increased pain, levels of exudate, cellulitis etc.) should be excluded from the evaluation. Colonised/ critically colonised wounds are not excluded from the evaluation. Site standard protocol should be implemented to address bacterial burden; †Wounds that have healed by <10% but have shown significant improvement in granulation tissue quality/ quantity may be considered for further PICO treatment based on clinician judgement.
ABPI: Ankle–brachial pressure index
VLU: Venous leg ulcers

Products portfolio (T. – E.)

Use MolecuLight *i:X*™ wound assessment tool to measure wound surface area and evaluate bioburden level



*Level of exudate for wounds suitable for NPWT. †PROSHIELD Range includes PROSHIELD Foam & Spray and PROSHIELD Plus Skin Protectant.

1. Schultz GS, Sibbald RG, Falanga V, *et al*. Wound bed preparation: a systematic approach to wound management. *Wound Rep Reg* (2003);11:1-28. **2.** Leaper DJ, Schultz G, Carville K, Fletcher J, Swanson T, Drake R. Extending the TIME concept: what have we learned in the past 10 years? *Int Wound J* 2012; 9 (Suppl. 2):1–19.

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PROSHIELD◊ Range
helping to maintain skin integrity

For use on intact and injured skin associated with incontinence[1-4]

Safe and effective

Safe and effective for the management of moisture related skin damage.[3-5]

26% reduction

A study has observed a combined 26% reduction in the incidence of pressure ulcers and incontinence-associated dermatitis (IAD) when a comprehensive skin care regime*, including the PROSHIELD system, was implemented.*[2]

*Compared to prior standard of care

Prevent and protect more

Helps prevent and protect skin from IAD and moisture lesions.[1,3-5]

1. Flynn D, Williams S. Barrier creams for skin breakdown, *Nursing & Residential Care*. 2011; 13 (11): 553-558. **2.** Wall L, Vernon T. Launch of a Skin Care Regime to reduce the incidence of Moisture Associated Skin Damage. Doncaster and Bassetlaw NHS Foundation Trust. Presented at TVS, UK, 2016. **3.** Maxwell J, Sinclair D. Treatment of moisture related lesions in children. Great Ormond St Hospital for Children NHS Foundation Trust, London UK. Poster presented at EWMA 2012, Vienna, Austria. **4.** Meuleneire, F. A new solution in the treatment of moisture lesions. AZ St Elisabeth Zottegem, Belgium. Presented at EPUAP 2010. **5.** Ling L. Proshield skin care protective system: A sequence of evaluations. Gloucestershire NHS, UK. Presented at Wounds UK, 2011.

PROSHIELD◊ Foam & Spray Incontinence Cleanser

Effective prevention and management of moisture lesions and IAD without rinsing or the use of a moisturiser, when used with PROSHIELD PLUS Skin Protectant.[1-3]

26%

Contributed to prevention of pressure ulcers and IAD[3]

pH balanced[4]

Formulated to help eliminate odour[5]

1. Ling L. Proshield skin care protective system: A sequence of evaluations. Gloucestershire NHS, UK. Presented at Wounds UK, 2011. **2.** Flynn D, Williams S. Barrier creams for skin breakdown, *Nursing & Residential Care*. 2011; 13 (11): 553-558. **3.** Wall L, Vernon T. Launch of a Skin Care Regime to reduce the incidence of Moisture Associated Skin Damage. Doncaster and Bassetlaw NHS Foundation Trust. Presented at TVS, UK, 2016. **4.** Smith+Nephew 2019. Review of certificate of analysis for PROSHIELD Foam & Spray Incontinence Cleanser. RD/19/024. **5.** Technical file PROSHIELD Foam & Spray incontinence cleanser (product formulation/ specifications).

PROSHIELD◊ PLUS
Skin Protectant

Smooth, viscous and fragance free moisture barrier.[1,2]

Helps protect skin against IAD and moisture lesions[3-6]

Safe and effective for the management of moisture related skin damage[3,5,6]

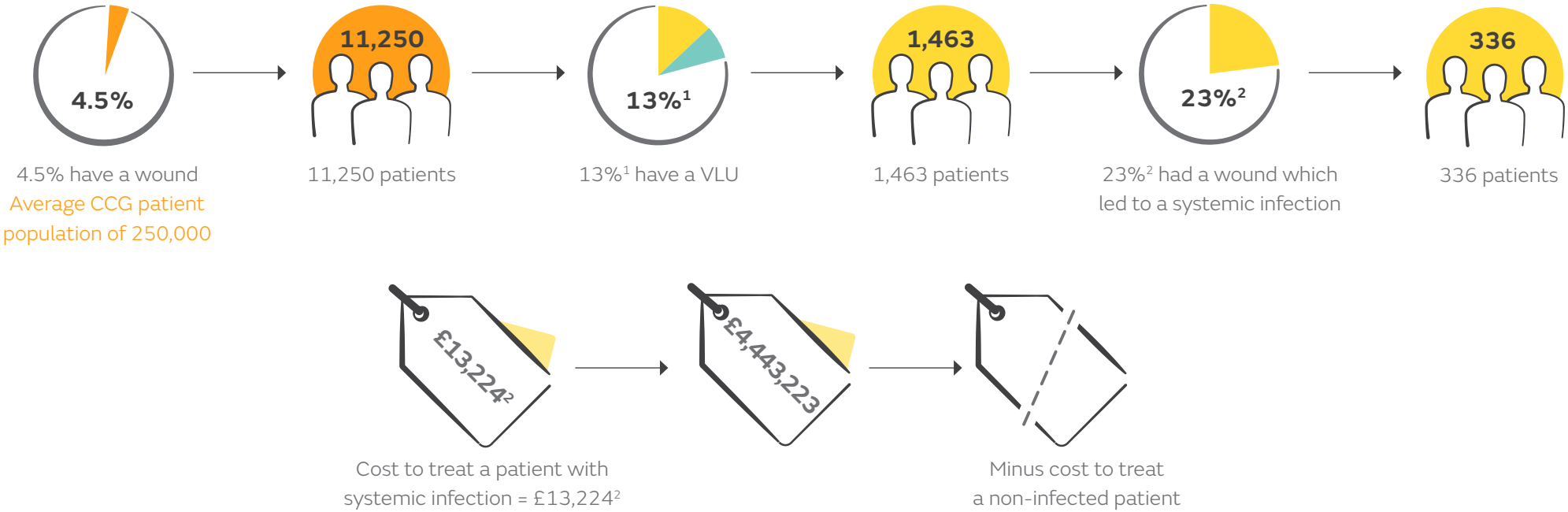
Moisturises and conditions the skin[7,8]

1. Smith+Nephew 2019. Review of Certificate of Analysis for PROSHIELD Plus Skin Protectant RD.19.016. **2.** Smith & Nephew 2019. Verification report for the viscosity of PROSHIELD PLUS Skin Protectant. U/064/R3. **3.** Ling L. PROSHIELD skin care protective system: A sequence of evaluations. Gloucestershire NHS, UK. Presented at Wounds UK, 2011. **4.** Flynn D, Williams S. Barrier creams for skin breakdown, *Nursing & Residential Care*. 2011; 13 (11): 553-558. **5.** Maxwell J, Sinclair D. Treatment of moisture related lesions in children. Great Ormond St Hospital for Children NHS Foundation Trust, London UK. Poster presented at EWMA 2012, Vienna, Austria. **6.** Meuleneire F. A new solution in the treatment of moisture lesions. AZ St Elisabeth Zottegem, Belgium. Presented at EPUAP 2010. **7.** Hoggarth A, Waring M, Alexander J, Greenwood A, Callaghan T. A controlled three-part trial to investigate the barrier function and skin hydration properties of six skin protectants. *Ostomy wound man* 2005; 51(12): 30-42. **8.** Howers L, Boyett F. Evaluation of Proshield Plus in nursing homes for inclusion onto formulary in a healthcare trust. NHS Surrey. Presented at Wounds UK 2012.

Cost of wounds

Cost of wounds

Costs of a systemic infection in VLU for an average CCG*



4.5% have a wound
Average CCG patient population of 250,000

11,250 patients

13%[1] have a VLU

1,463 patients

23%[2] had a wound which led to a systemic infection

336 patients

Cost to treat a patient with systemic infection = £13,224[2]

Minus cost to treat a non-infected patient

Minimum total cost for one year in one CCG = £3,328,767

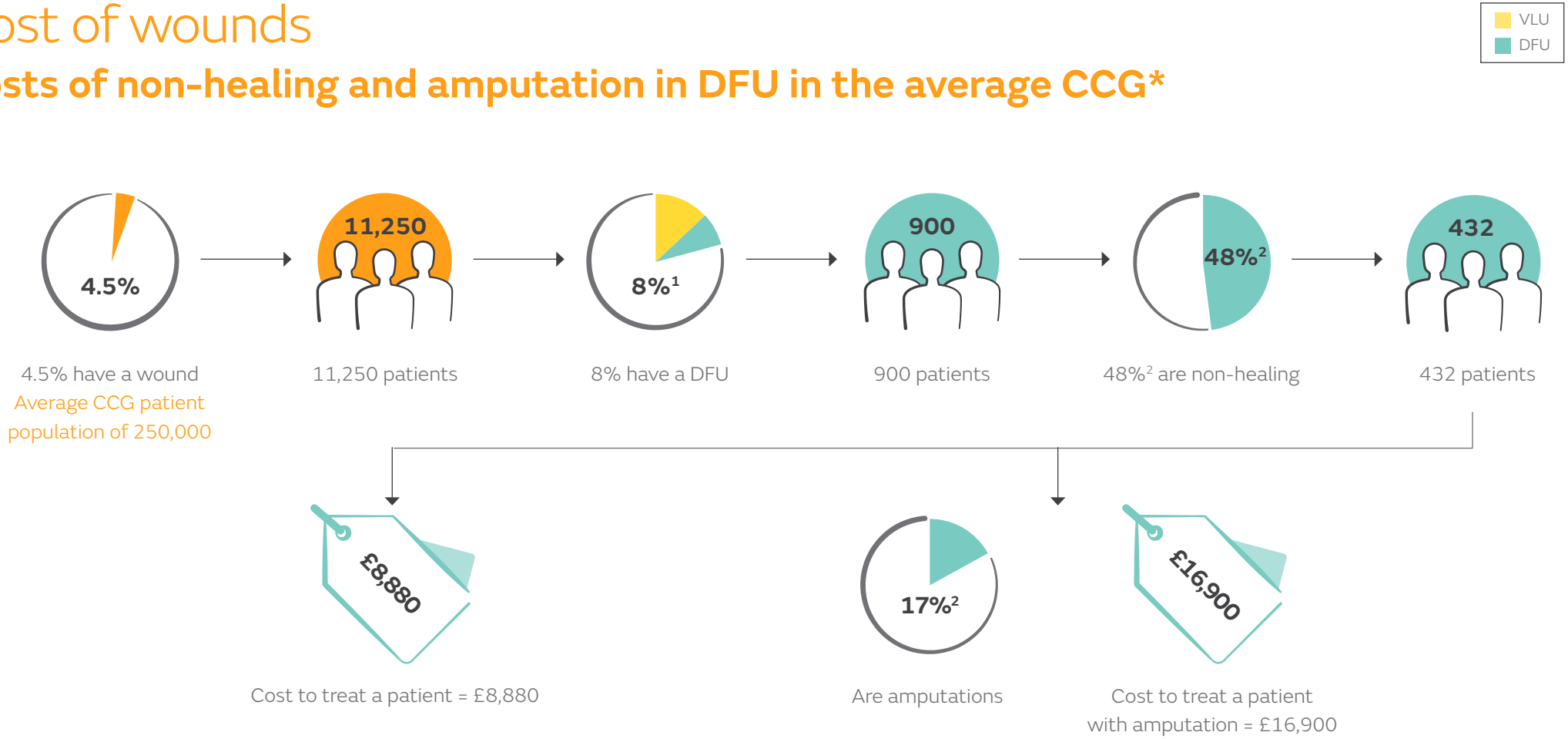
*Potential cost savings are based on average incidence and costs reported and applied to an average size clinical commissioning group (CCG)

1. Guest JF, *et al*. Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open*. 2015;5:e009283. **2.** Guest JF. Costs and consequences of managing infection associated with venous leg ulcers in the UK. Presented at: CATALYST Health Economics Consultants Ltd Northwood; 2017; Middlesex, UK.

The costs associated with the treatment may vary between clinical commissioning groups and healthcare models.

Cost of wounds

Costs of non-healing and amputation in DFU in the average CCG*



4.5% have a wound
Average CCG patient population of 250,000

11,250 patients

8% have a DFU

900 patients

48%[2] are non-healing

432 patients

Cost to treat a patient = £8,880

Are amputations

Cost to treat a patient with amputation = £16,900

Minimum DFU cost for non-healing for one year in one CCG = £3,801,600

Minimum DFU cost with amputation for one year in one CCG = £1,233,700

*Potential cost savings are based on average incidence and costs reported and applied to an average size clinical commissioning group (CCG)

1. Guest JF, *et al*. Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open*. 2015;5:e009283. **2.** Guest JF. Costs and consequences of managing infection associated with venous leg ulcers in the UK. Presented at: CATALYST Health Economics Consultants Ltd Northwood; 2017; Middlesex, UK.

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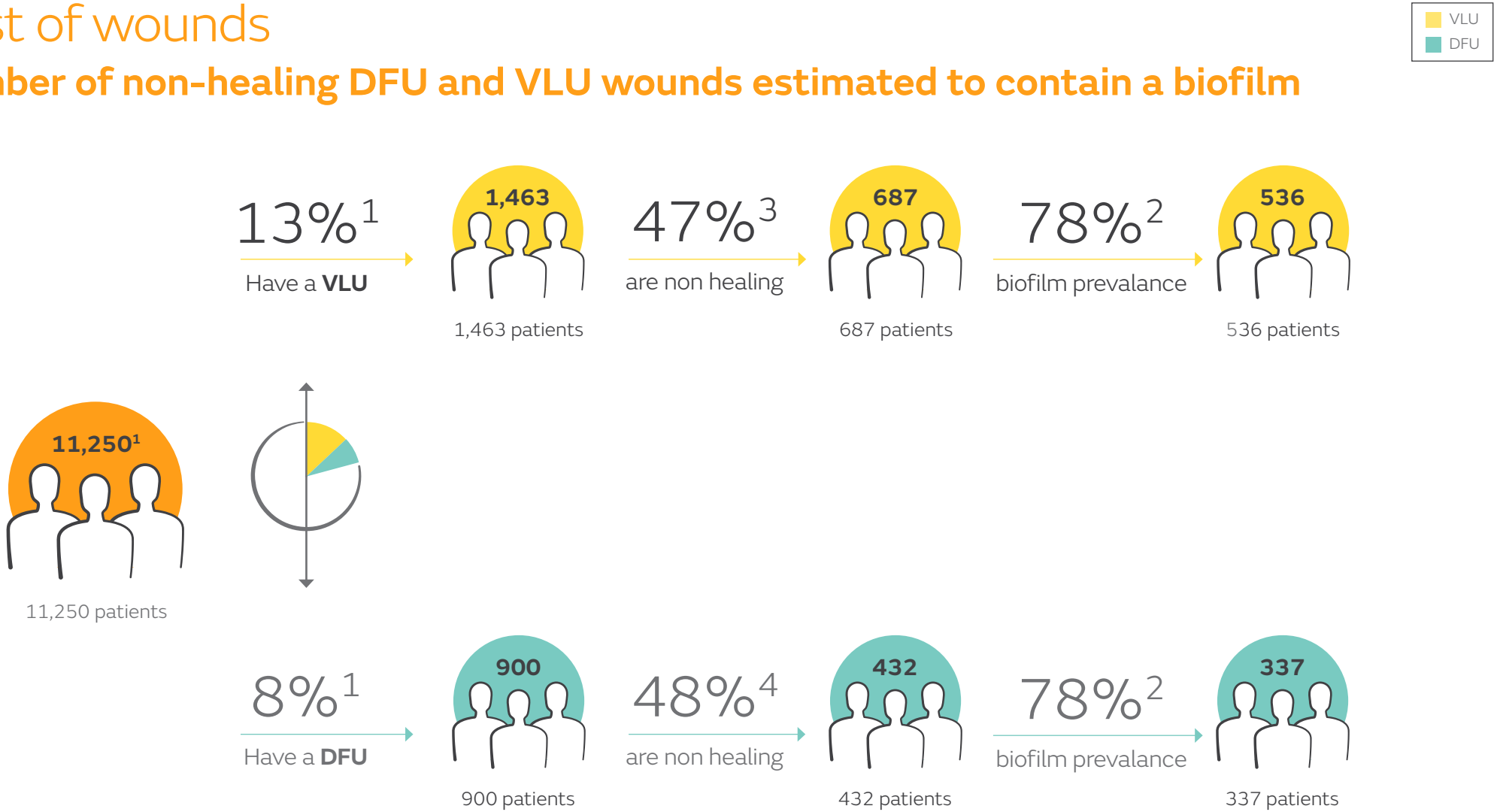
Cost of wounds

Number of non-healing DFU and VLU wounds estimated to contain a biofilm

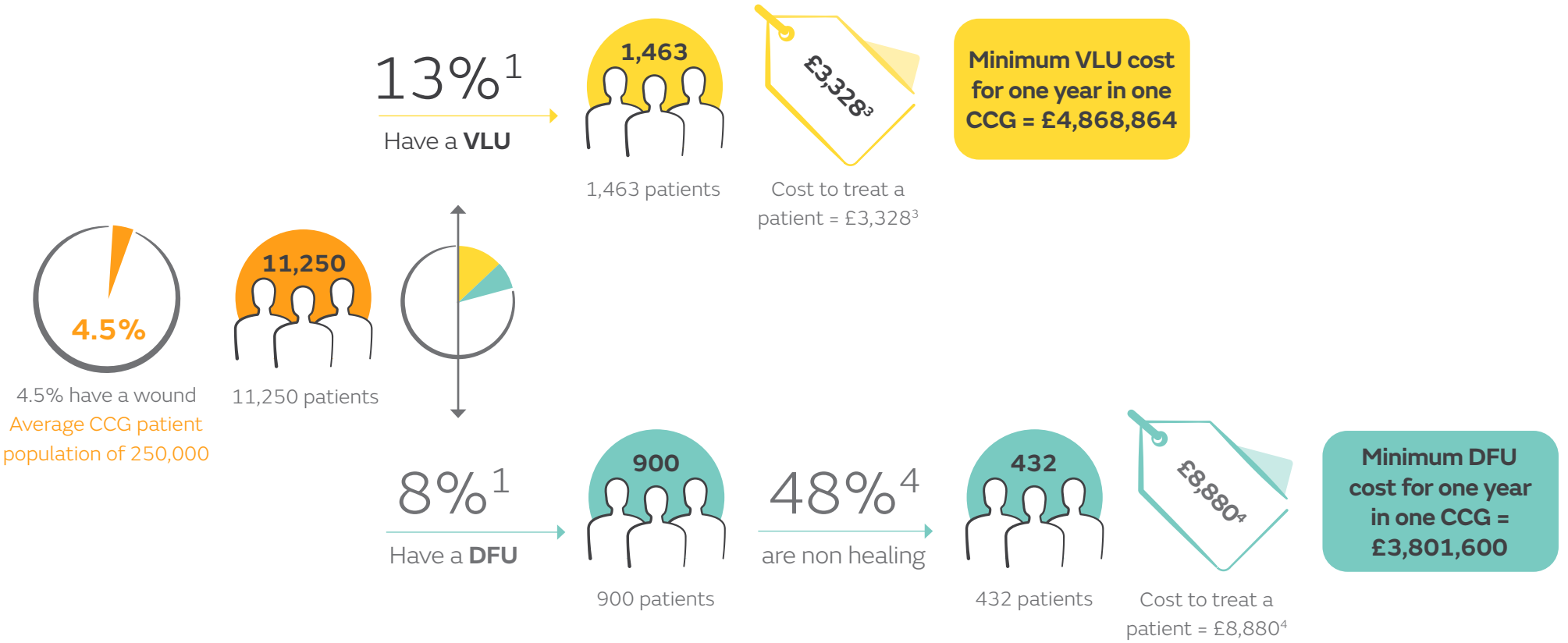


1. Guest JF, *et al*. Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open*. 2015;5:e009283. **2.** Malone M, *et al*. The prevalence of biofilms in chronic wounds: a systematic review and meta-analysis of published data. *J. Wound Care*. 2017;26:20–25. **3.** Guest JF, Fuller GW, Vowden P. Venous leg ulcer management in clinical practice in the UK: costs and outcomes. *Int. Wound J*. 2018;15:29–37. **4.** Guest JF, Fuller GW, Vowden P. Diabetic foot ulcer management in clinical practice in the UK: costs and outcomes. *Int. Wound J*. 2018;15:43–52.

The costs associated with the treatment may vary between clinical commissioning groups and healthcare models.

Cost of wounds

Number of non-healing DFU and VLU for an average CCG*



*Potential cost savings are based on average incidence and costs reported and applied to an average size clinical commissioning group (CCG)

1. Guest JF, *et al*. Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open*. 2015;5:e009283. **2.** Malone M, *et al*. The prevalence of biofilms in chronic wounds: a systematic review and meta-analysis of published data. *J. Wound Care*. 2017;26:20–25. **3.** Guest JF, Fuller GW, Vowden P. Venous leg ulcer management in clinical practice in the UK: costs and outcomes. *Int. Wound J*. 2018;15:29–37. **4.** Guest JF, Fuller GW, Vowden P. Diabetic foot ulcer management in clinical practice in the UK: costs and outcomes. *Int. Wound J*. 2018;15:43–52.

The costs associated with the treatment may vary between clinical commissioning groups and healthcare models.

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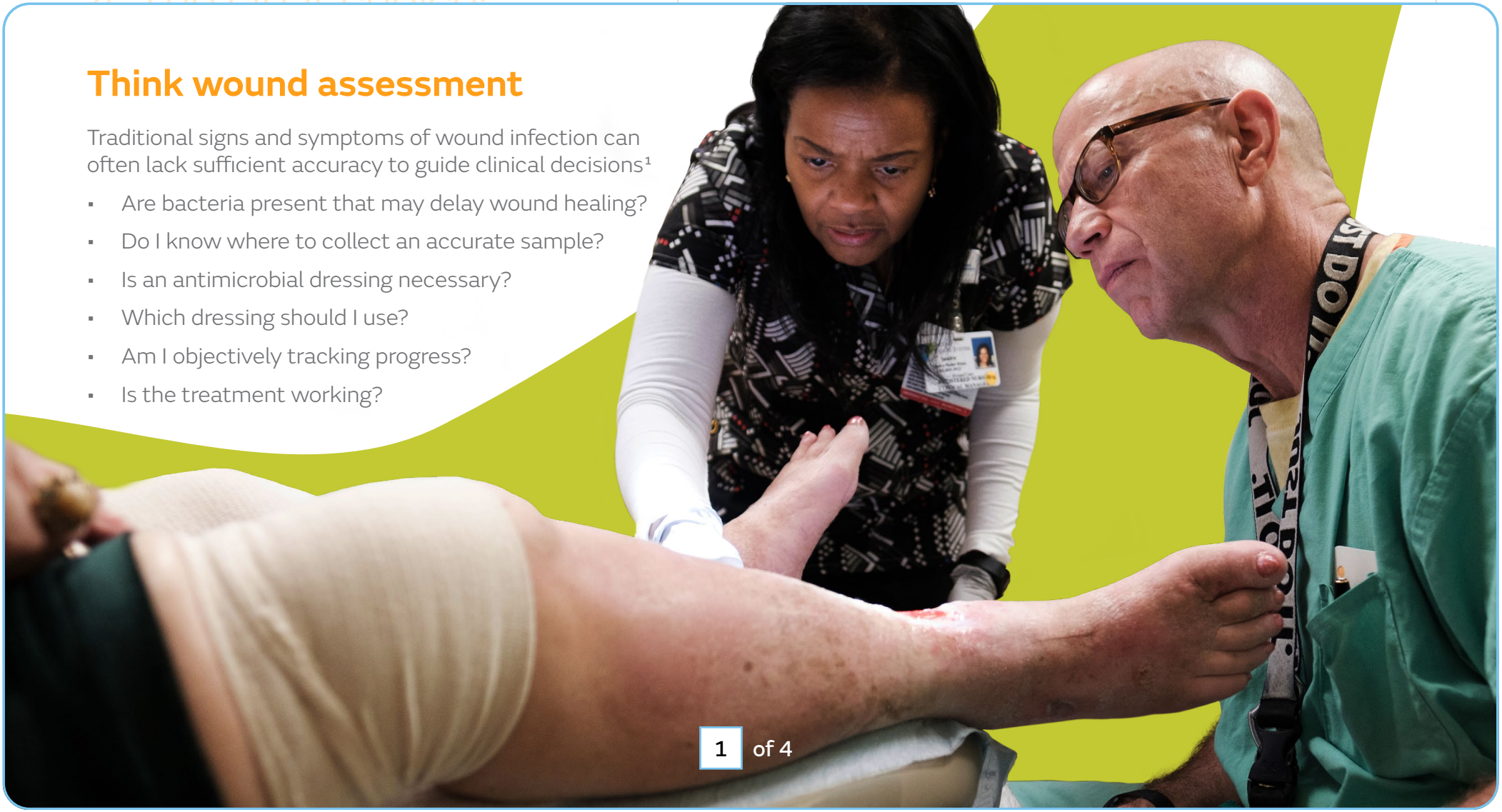
Think wound assessment

Traditional signs and symptoms of wound infection can often lack sufficient accuracy to guide clinical decisions[1]

- Are bacteria present that may delay wound healing?
- Do I know where to collect an accurate sample?
- Is an antimicrobial dressing necessary?
- Which dressing should I use?
- Am I objectively tracking progress?
- Is the treatment working?



1 of 4

1. Hoeflok J, Teene L, Chamma E, Chu A, DaCosta RS. Pilot clinical evaluation of surgical site infections with a novel handheld fluorescence imaging device. Proceedings of the Annual Military Health System Research Symposium (MHSRS); 2014 Aug 18- 21; Fort Lauderdale, FL.

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MolecuLight *i*:X™

Make it part of your standard care

A recent pilot study concluded that incorporating MolecuLight *i*:X™ into the standard of care allowed clinicians to optimise therapy preparation, guide sampling and treatments, and track bacterial status to better determine therapy results.[1]

- MolecuLight *i*:X™ leverages the principle of fluorescence to visualise bacteria
- It emits safe, violet light which causes bacteria to fluoresce and is detectable at ≥10^4 CFU/g^2

1. DaCosta RS, Kulbatski I, Lindvere-Teene L, Starr D, Blackmore K, Silver JI, *et al.* Point-of-care autofluorescence imaging for real-time sampling and treatment guidance of bioburden in chronic wounds: first-in-human results. *PLOS one*. 2015 Mar 19;10(3). **2.** Rennie MY, Lindvere-Teene L, Tapang K, Linden R, Point-of-care fluorescence imaging predicts the presence of pathogenic bacteria in wounds: a clinical study. *Journal of Wound Care* 2017;26(8):452-460.

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Smith+Nephew

MolecuLight *i*:X™

Distributed by Smith+Nephew

THINK

Now you can better assess the presence of bacteria and measure wound surface area

Quickly

Safely

Easily

Visualise fluorescent bacteria[1] and measure wound surface area at the point of care[1]

1. DaCosta RS, Kulbatski I, Lindvere-Teene L, Starr D, Blackmore K, Silver JI, *et al.* Point-of-care autofluorescence imaging for real-time sampling and treatment guidance of bioburden in chronic wounds: first-in-human results. *PLOS one.* 2015 Mar 19;10(3).

Journal of Wound Care, Vol 18, No 10, October 2009.

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Smith+Nephew

MolecuLight i:X

Distributed by Smith+Nephew

THINK

How to empower your clinical practice

Better resource management*

Has been shown to facilitate more responsible decision making on dressings, antimicrobials and antibiotics at the point of care[1,2]

Fewer ineffective wound treatments*

Instead, informed dressing selection and objective feedback to track efficacy

Optimising therapies

Optimising therapies and supports responsible antimicrobial stewardship[1,2]

More effective sampling

Visualises the location and distribution of bacterial load across the wound bed and periphery resulting in more accurate swabbing[3]

*Compared to standard of care.

1. Hill R, Douglas JJ. Real-time bacterial fluorescence imaging guides antimicrobial stewardship in patients with diverse wounds. Proceedings of the Annual Symposium on Advanced Wound Care (SAWC); 2017 Apr 5-9; San Diego, CA. **2.** Landis S. Use of fluorescence imaging in visualizing bacteria in chronic ulcers and traumatic soft tissue damage. Proceedings of the Annual Meeting of the Society of Federal Health Professionals (AMSUS); 2016 Nov 29-Dec 2; National Harbor, MD. **3.** Ottolino-Perry K, Chamma E, Blackmore KM, Lindvere-Teene L, Starr D, Tapang K, *et al.* Improved detectio of wound bacteria using fluorescence image guided wound sampling in diabetic foot ulcers. *Int Wound J.* 2017 Feb 28. doi: 10.1111/iwj.12717.

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Smith+Nephew

MolecuLight i:X

Distributed by Smith+Nephew

4. The clear choice:

A non-adherent hydrogel that rehydrates necrotic tissue, promoting autolytic debridement.[1-9]

✓	**Effective debridement and desloughing**[3,10] Effective rehydrating action can produce debridement of necrotic tissue[2-6] whilst preserving the surrounding viable skin.[3,5,10]
✓	**Easy application**[3,6,11] The unique APPLIPAK◊ system provides simple, directable and controlled application.[3,6,11-13]
✓	**Autolytic debridement can be carried out by any clinician**

Also available as INTRASITE CONFORMABLE
Conformable Hydrogel Dressing

1. Jones A, Vaughan D. Hydrogel dressings in the management of a variety of wound types: A review. *Journal of Orthopaedic Nursing*. 2005;9. **2.** Smith+Nephew 2011.Physical and chemical properties of INTRASITE Gel APPLIPAK. Internal report. DS/11/008/R4. **3.** Colin D, Kurring Pa, Yvon C. Managing sloughy pressure sores. *J Wound Care*. 1996;5(10):444–446. **4.** Cassino R, Ricci E, Carusone A. A conformable hydrogel in the debridement of complex necrotic wounds. Paper presented at: EWMA; 1997; Milan. **5.** Smith+Nephew 2020. Use of literature and data to support the INTRASITE Mode of Action. Internal report. EO.AWM.PCSgen.004.v2. **6.** Flanagan M. The efficacy of a hydrogel in the treatment of wounds with non-viable tissue. *Journal of Wound Care*. 1995;4(6):264–7. **7.** Thomas S, Fear M. The efficacy of INTRASITE gel as a debrider of non-viable tissue from wounds treated in the community. Paper presented at: EWMA; 1993; Harrogate, UK. **8.** Thomas S, Fear M. Comparing two dressings for wound debridement. *Journal of Wound Care*. 1993;2(5):272–274. **9.** Williams C. Intrasite Gel: a hydrogel dressing. *British journal of nursing* (Mark Allen Publishing). 1994;3(16):843–846. **10.** Bale S, Banks V, Haglestein S, Harding KG. A comparison of two amorphous hydrogels in the debridement of pressure sores. *Journal of Wound Care*. 1998;7(2):65-68. **11.** Smith+Nephew. A pilot study comparing INTRASITE GEL with saline soaked gauze for debridement. Internal report. CTR90/08. **12.** Young T, Williams C, Benbow M, *et al*. A study of two hydrogels used in the management of pressure sores. Proceedings of the Sixth European Conference on Advances in Wound Management; 1997; London. **13.** Smith+Nephew 2018. Simulated in-use testing, transparency testing and dilution testing of INTRASITE GEL. Internal report U/004/R1.

MolecuLight i:X

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VERSAJET

VERSAJET

Adapted from Chadwick P. et al. A dynamic care pathway to coordinate the use of advanced therapy in a diabetic foot ulveration. Journal of Wound Care, Vol 18, No 10, October 2009.

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4. The clear choice:
a pathway to guide appropriate

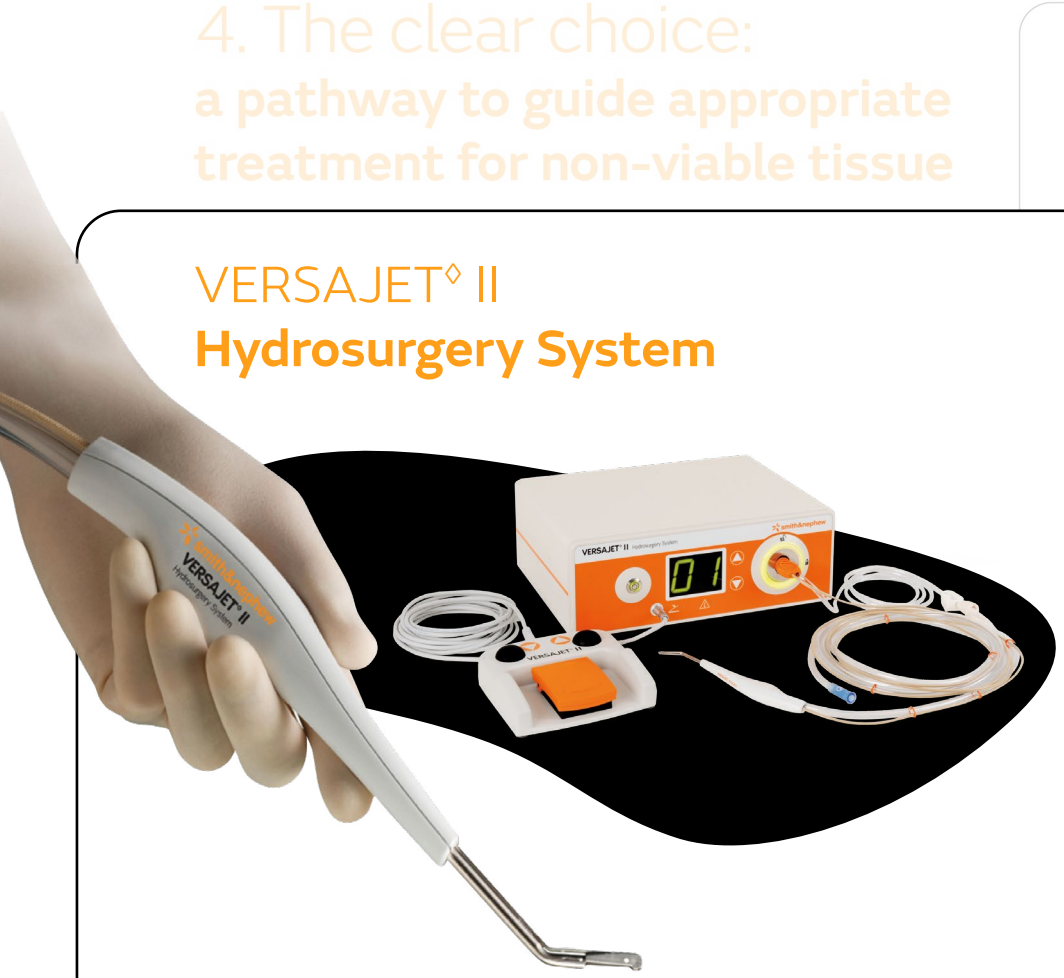
IODOSORB◊
0.9% Cadexomer Iodine Dressings

✓	Promotes wound bed preparation by removing barriers to healing from the wound[1-8]*
✓	Effective desloughing[5,9]
✓	Assists with autolytic debridement by absorbing slough and debris[2,3,5,10]
✓	Removes/absorbs pus and debris[1-10]
✓	Can be removed without damaging newly formed ephithelium[11-13]

*e.g. slough, pus, debris and biofilm

1. Skog E, Arnesjo B, Troeng T, *et al.* A randomized trail comparing cadexomer iodine and standard treatment in the out-patient management of chronic venous ulcers. *British Journal of Dermatology*. 1983;109:77–83. **2.** Troeng T, Skog E, Arnesjo B, *et al.* A randomised multicentre trial to compare the efficacy of cadexomer iodine and standard treatment in the management of chronic venous ulcers in out-patients. Stuttgart: Schattauer Verlag; 1983. **3.** Holloway GA, Johansen KH, Barnes RW, Pierce GE. Multicenter trial of cadexomer iodine to treat venous stasis ulcer. *The Western Journal of Medicine*. 1989;151(1):35–38. **4.** Malone M, Johani K, Jensen SO, *et al.* Effect of cadexomer iodine on the microbial load and diversity of chronic non-healing diabetic foot ulcers complicated by biofilm *in vivo*. *J Antimicrob Chemother*. 2017;72(7):2093–2101. **5.** Hansson C, Persson L-M, Stenquist B, *et al.* The effects of cadexomer iodine paste in the treatment of venous leg ulcers compared with hydrocolloid dressing and paraffin gauze dressing. *International Journal of Dermatology*. 1998;37(390–396). **6.** Moberg S, Hoffman L, Grennert M-L, Holst A. A randomized trial of cadexomer iodine in decubitus ulcers. *Journal of American Geriatrics Society*. 1983;31(6):462–465. **7.** Harcup JW, Saul PA. A study of the effect of cadexomer iodine in the treatment of venous leg ulcers. *The British Journal of Clinical Practise*. 1986;40(9):360–364. **8.** Lantis JC. Cadexomer iodine on a biofilm in diabetic foot ulcers: A Pilot study. Paper presented at: WUWHS; 2016; Florence. **9.** Smith+Nephew 2007. An evaluation of the use of IODOSORB ointment and dressing in the management of chronic exuding wounds. Internal report. SR/CE/027/IOD. **10.** Ormiston MC, Seymour MTJ, Venn GE, Cohen RI, Fox JA. Controlled trial of IODOSORB in chronic venous ulcers. *British Medical Journal*. 1985;291:308–310. **11.** Smith+Nephew 2017.IODOSORB Powder Wound Model Testing - 3 day cavity testing with ALLEVYN GENTLE BORDER secondary dressing using horse serum at a flow rate modelling that of a moderately exuding wound. Internal report. DS/17/249/R. **12.** Smith+Nephew 2017. IODOSORB / IODOFLEX Dressing Wound Model Testing - 3 day cavity testing with ALLEVYN Gentle Border secondary dressing using horse serum at a low rate modelling that of a moderatly exuding wound. Internal report. DS/17/247/R. **13.** Johnson A. A combative healer with no ill-effect. IODOSORB in the treatment of infected wounds. *Professional Nurse*. 1991;7(1):60-64.

4. The clear choice:
a pathway to guide appropriate treatment for non-viable tissue



VERSAJET◊ II
Hydrosurgery System

The VERSAJET system provides controlled debridement and facilitates precise excision of necrosis and other unwanted material from the wound surface, thus preserving viable tissue[1,2]

Helps enable a surgeon to:

✓	Preserve viable tissue[1,2] and reduce number of debridement procedures[3,4]*
✓	In a case study, VERSAJET System effectively removed large amounts of embedded contaminants (such as road dirt) that could act as nuclei for infection[5]
✓	Create a smooth wound bed which may enhance graft take[6]

*VERSAJET has been shown to have less operating procedures compared to sharp debridement

1. Hyland EJ, D'cruz R, Menon S, *et al.* Prospective, randomised controlled trial comparing VERSAJET Hydrosurgery and conventional debridement of partial thickness paediatric burns. *BURNS*. 2015;41(4):700–707. **2.** Matsumura H, Nozaki M, Watanabe K, *et al.* The estimation of tissue loss during tangential hydrosurgical debridement. *Annals of Plastic Surgery*. 2012;69(5):521–525. **3.** Granick MS, Posnett J, Jacoby M, *et al.* Efficacy and cost-effectiveness of a high-powered parallel waterjet for wound debridement. *Wound Repair and Regeneration*. 2006;14(4):394–397. **4.** Smith & Nephew 2005. The use of VERSAJET in the limb salvage following failure of minor amputation in diabetic foot. Internal report. **5.** Chammas MF, Gurunluoglu R, Carlsen SN, *et al.* Surgical debridement of mineral pitch and nonviable penile tissue using water-jet power: a preliminary report. *BJU International* 2008;103(7):974–976. **6.** Vanwiljck R, Kaba L, Boland S, *et al.* Immediate skin grafting of sub-acute and chronic wounds debrided by hydrosurgery. *Journal of Plastic, Reconstructive & Aesthetic Surgery*. 2010;63:544–549.

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5. The clear choice

Clinical signs and symptoms of infection[1] (CSI)

Localised infection (secondary)	Spreading infection (classic/acute)
New increased or altered pain†	As for localised infection plus:
Delayed or stalled healing†	Wound breakdown†
Periwound oedema	Erythema extending from wound edge
Bleeding or friable (easily damaged) granulation tissue	Crepitus, warmth or discoloration spreading in the periwound area
Distinctive malodour or change in odour	Lymphangitis
Wound bed discolourisation	Malaise or other non specific deterioration in patients general condition
Increased or altered / purulent exudate	–
Induration (increase fibrous tissue)	–
Pocketing	–
Bridging	–

†Individually highly indicative of infection. Infection is also highly likely in the presence of two or more of the other signs listed.

1. Ayello EA, *et al.* International consensus. Appropriate use of silver dressings in wounds. An expert working group consensus. *Wounds Int.* 1–24 (2012).

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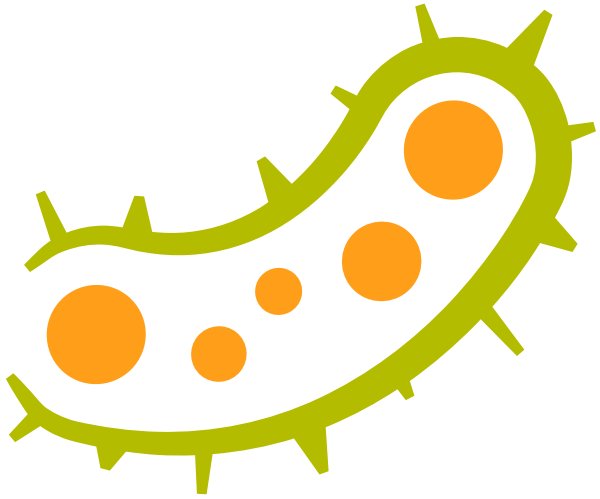
5. The clear choice
A pathway to guide

Signs and symptoms of a biofilm



- Recurrent infections
- Antimicrobial therapy failure
- Delayed wound healing
- Infection symptoms may be less obvious
- Lab identification culture negative
- Immune response to biofilm; low level inflammation and damage to surrounding tissue

Schultz G, *et al*. Consensus guidelines for the identification and treatment of biofilms in chronic nonhealing wounds. *Wound Repair Regen*. 25, 744–757 (2017).

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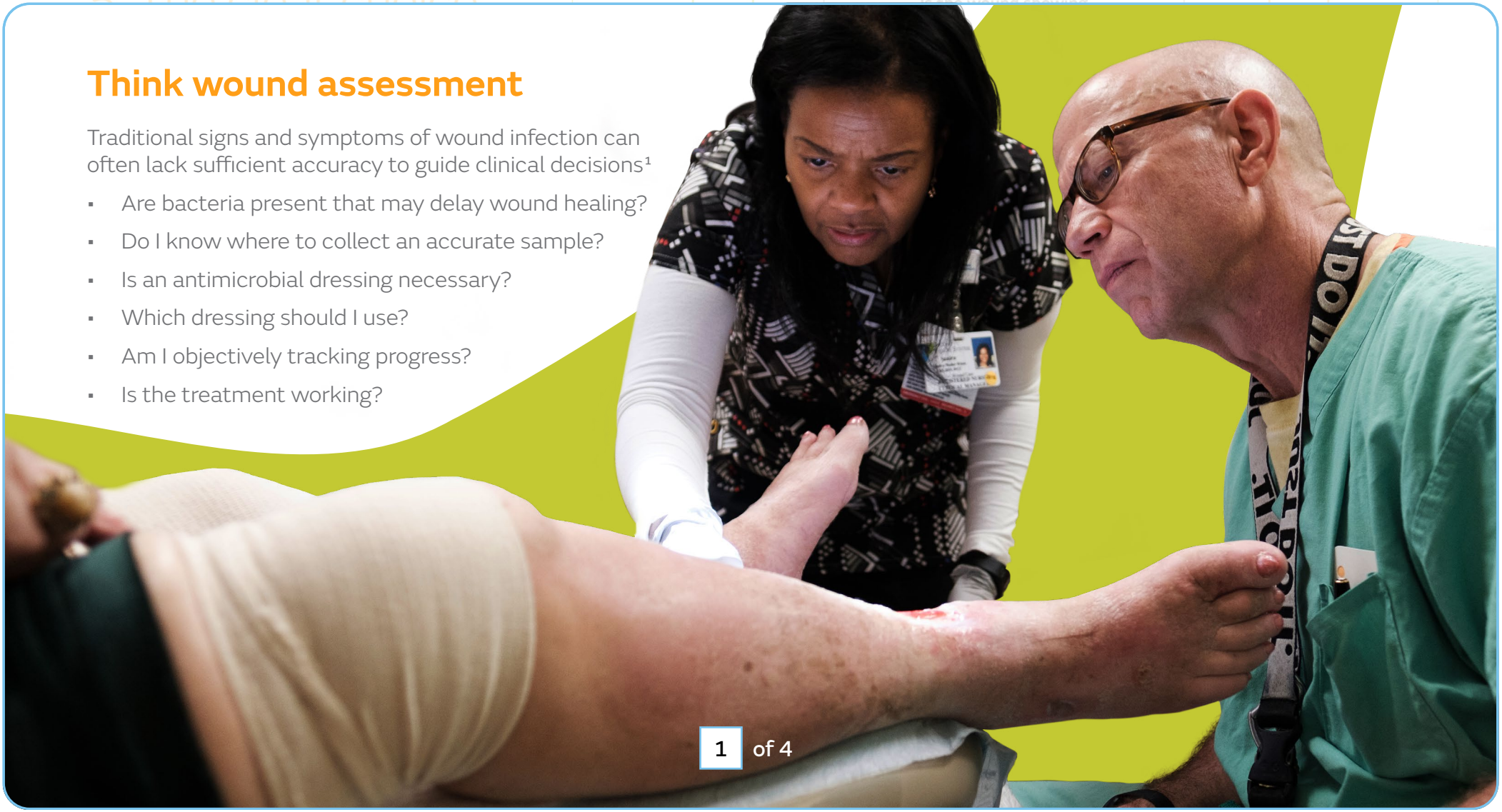
Think wound assessment

Traditional signs and symptoms of wound infection can often lack sufficient accuracy to guide clinical decisions[1]

- Are bacteria present that may delay wound healing?
- Do I know where to collect an accurate sample?
- Is an antimicrobial dressing necessary?
- Which dressing should I use?
- Am I objectively tracking progress?
- Is the treatment working?



1 of 4

1. Hoeflok J, Teene L, Chamma E, Chu A, DaCosta RS. Pilot clinical evaluation of surgical site infections with a novel handheld fluorescence imaging device. Proceedings of the Annual Military Health System Research Symposium (MHSRS); 2014 Aug 18- 21; Fort Lauderdale, FL.

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MolecuLight *i*:X™

Make it part of your standard care

A recent pilot study concluded that incorporating MolecuLight *i*:X™ into the standard of care allowed clinicians to optimise therapy preparation, guide sampling and treatments, and track bacterial status to better determine therapy results.[1]

- MolecuLight *i*:X™ leverages the principle of fluorescence to visualise bacteria
- It emits safe, violet light which causes bacteria to fluoresce and is detectable at ≥10^4 CFU/g[2]

1. DaCosta RS, Kulbatski I, Lindvere-Teene L, Starr D, Blackmore K, Silver JI, *et al.* Point-of-care autofluorescence imaging for real-time sampling and treatment guidance of bioburden in chronic wounds: first-in-human results. *PLOS one*. 2015 Mar 19;10(3). **2.** Rennie MY, Lindvere-Teene L, Tapang K, Linden R, Point-of-care fluorescence imaging predicts the presence of pathogenic bacteria in wounds: a clinical study. *Journal of Wound Care* 2017;26(8):452-460.

representative for further details on products available in your market.
Intended for healthcare professionals outside of the US only.
‡CSI = Clinical signs of infection
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Use (IFU) prior to use. It is the responsibility of healthcare professionals to determine and utilise the appropriate products and techniques according to their own clinical judgment for each of their patients.
Smith+Nephew
MolecuLight i:X
Distributed by Smith+Nephew

THINK

Now you can better assess the presence of bacteria and measure wound surface area

Quickly

Safely

Easily

Visualise fluorescent bacteria[1] and measure wound surface area at the point of care[1]

1. DaCosta RS, Kulbatski I, Lindvere-Teene L, Starr D, Blackmore K, Silver JI, *et al.* Point-of-care autofluorescence imaging for real-time sampling and treatment guidance of bioburden in chronic wounds: first-in-human results. *PLOS one.* 2015 Mar 19;10(3).

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‡Unless Iodine contraindicated CSI – Clinical signs of infection. BBWC = Biofilm based wound care, Schultz, 2017.
‡CSI = Clinical signs of infection

DURAFIBER Ag

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Smith+Nephew

MolecuLight i:X

Distributed by Smith+Nephew

THINK

How to empower your clinical practice

Better resource management*

Has been shown to facilitate more responsible decision making on dressings, antimicrobials and antibiotics at the point of care[1,2]

Fewer ineffective wound treatments*

Instead, informed dressing selection and objective feedback to track efficacy

Optimising therapies

Optimising therapies and supports responsible antimicrobial stewardship[1,2]

More effective sampling

Visualises the location and distribution of bacterial load across the wound bed and periphery resulting in more accurate swabbing[3]

*Compared to standard of care.

1. Hill R, Douglas JJ. Real-time bacterial fluorescence imaging guides antimicrobial stewardship in patients with diverse wounds. Proceedings of the Annual Symposium on Advanced Wound Care (SAWC); 2017 Apr 5-9; San Diego, CA. **2.** Landis S. Use of fluorescence imaging in visualizing bacteria in chronic ulcers and traumatic soft tissue damage. Proceedings of the Annual Meeting of the Society of Federal Health Professionals (AMSUS); 2016 Nov 29-Dec 2; National Harbor, MD. **3.** Ottolino-Perry K, Chamma E, Blackmore KM, Lindvere-Teene L, Starr D, Tapang K, *et al*. Improved detection of wound bacteria using fluorescence image guided wound sampling in diabetic foot ulcers. *Int Wound J*. 2017 Feb 28. doi: 10.1111/iwj.12717.

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Smith+Nephew

MolecuLight i:X

Distributed by Smith+Nephew

ACTICOAT◊

Antimicrobial Barrier Dressings Unique nanocrystalline silver technology

Our ACTICOAT range of dressings start killing bacteria in as little as 30 minutes.[1-4]

With a sustained action of up to seven days for ACTICOAT 7 and ACTICOAT FLEX 7 dressings,[5-9] and up to three days for ACTICOAT and ACTICOAT FLEX 3.[9-12]

✓	Fast acting[1-4]
✓	Releases silver into the wound[9-12]
✓	Sustained action up to 3 or 7 days[5-12] depending on variant

1. Wright JB, *et al.* (1998) Wound management in an era of increasing bacterial antibiotic resistance: A role for topical silver treatment, *American Journal of Infection Control*: 26(6):572–577. **2.** Wright JB, *et al.* (1998) Efficacy of topical silver against fungal burn wound pathogens, *American Journal of Infection Control* (1999); 27(4): 344–350. **3.** Driffield K. ACTICOAT FLEX 3 has antimicrobial activity in 30 minutes. Data on file 0810018, Smith & Nephew. **4.** Driffield K. ACTICOAT FLEX 7 has antimicrobial activity in 30 minutes. Data on file 0810014, Smith & Nephew. **5.** Westraim Report Ref. #001213. Long term comparative evaluation of Silverlon™ and ACTICOAT 7 Dressings. Activites against MRSA. **6.** Westraim Report Ref. #010322. Seven day efficacy of ACTICOAT 7 Dressings against multiple organisms. **7.** Driffield K. Antimicrobial activity of ACTICOAT FLEX 7 against a broad spectrum of wound pathogens. Data on file, reference 0810012. **8.** Driffield, K. Antimicrobial activity of ACTICOAT FLEX 7 dressings in a 7 day repeat challenge test. Data on file 0810013. **9.** Driffield K. Antimicrobial activity testing of ACTICOAT FLEX 7 dressings against a broad spectrum of wound pathogens using log reduction. Report reference WRP-TW141-022. **10.** Westaim Report Ref: # 971030. The Antimicrobial activity of Westaim's ACTICOAT Silver Coated Dressing against clinically relevant organsisms over an extended period of time. **11.** Driffield K. Antimicrobial activity of ACTICOAT FLEX 3 against a broad spectrum of wound pathogens. Data on file reference 0810016. **12.** Driffield K. Antimicrobial activity of ACTICOAT FLEX 3 Dressings in a 3 day repeat challenge test. Data on file 0810017.

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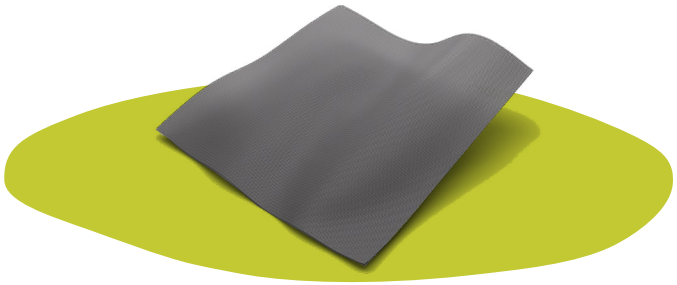
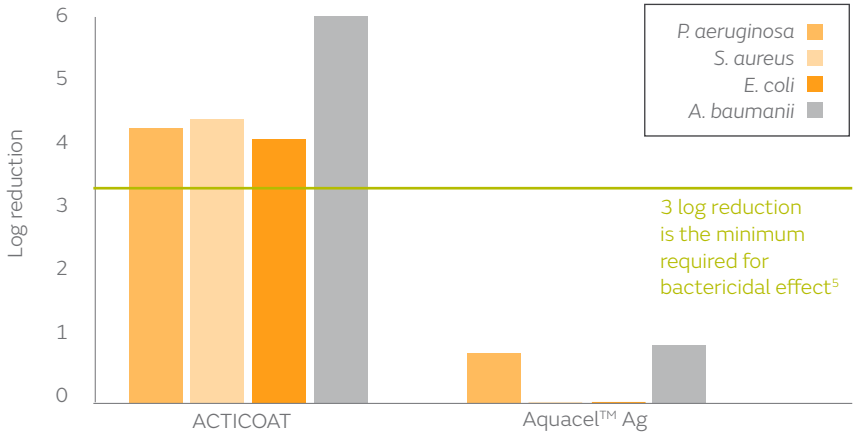
ACTICOAT◊
Antimicrobial Barrier Dressing



Picture indicates ACTICOAT FLEX 3

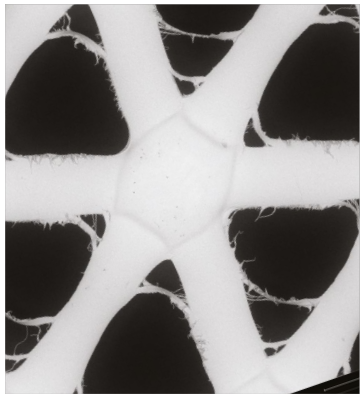


The power of nanocrystalline silver

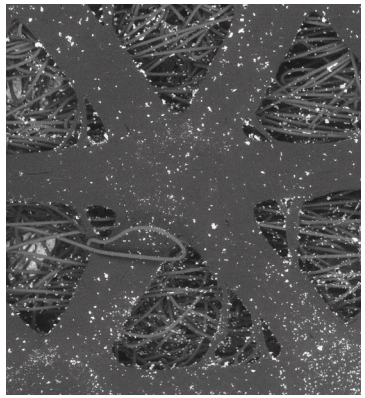
ACTICOAT has a unique nanocrystalline structure[1] with a high surface area of silver – enabling bactericidal silver[2] to come into contact with wound fluid.

ACTICOAT delivers enough silver, quickly, to sustain the concentration of Ag+ needed to be bactericidal.[3]

Low dose silver dressings run the risk of becoming inactive as the silver binds to other wound fluid components, leaving little to no available Ag^{+} to kill bacteria increasing the risk of wound infection.[4]



ACTICOAT's continuous coating of silver – 140 x magnification[6]



Less dense coating of silver – 140 x magnification[6]

1. Wright JB, *et al.* (1998) Wound management in an era of increasing bacterial antibiotic resistance: A role for topical silver treatment, *American Journal of Infection Control:* 26(6):572-577. **2.** Driffield K. Antimicrobial activity of ACTICOAT FLEX 7 against a broad spectrum of wound pathogens. Data on file 0810012, Smith+Nephew. **3.** Westaim Report Ref. #010322. Seven Day Efficacy of ACTICOAT 7 Dressings Against Multiple Organisms. **4.** Upton D. (2010) Pain and stress as contributors to delayed wound healing. *Wound Practice and Research.* **5.** Gago M, *et al.* (2008) A comparison of Three Silver – containing dressings in the treatment of infected, chronic wounds 20(10): 273-278. **6.** Daubney L. Silver Release Testing of ACTICOAT FLEX 7 Dressings. Report reference DS/08/062/R2.

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ACTICOAT◊
Antimicrobial Barrier Dressing

Sustained release of silver

ACTICOAT 7
ACTICOAT FLEX 7
Keeps on working for up to 7 days[6-8,14]

ACTICOAT
ACTICOAT FLEX 3
Keeps on working for up to 3 days[9-11,15]

From a patient perspective, fewer dressing changes reduces stress and trauma. Limiting disturbance to the wound can also lead to faster healing.[12]

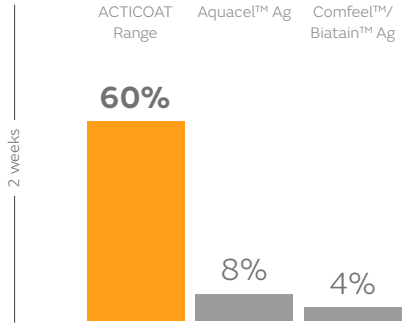
Fast acting

Kills bacteria in as little as 30 minutes (*in vitro*)[1-4]

In a clinical trial:

ACTICOAT dressing was shown to eliminate all signs and symptoms of infection in 60% of wounds within two weeks.[5]

% of wounds with no clinical signs of local infection after 2 weeks[5]



Broad spectrum efficacy

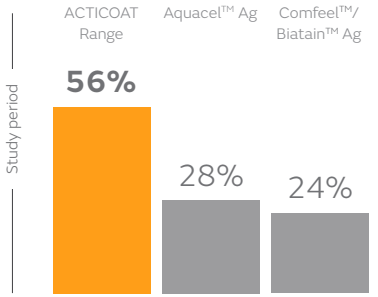
Effective against more than 150 pathogens:

Including Gram positive bacteria, Gram negative bacteria, yeasts and fungal wound pathogens (*in vitro*).[1,2,7,8,10,11,13]

In a clinical trial:

Patients treated with ACTICOAT dressing were nearly three times more likely to heal during the study than patients treated with other silver dressings.[5]

% of wounds healed in the study period of 8 weeks[5]



1. Wright JB, *et al.* (1998) Wound management in an era of increasing bacterial antibiotic resistance: A role for topical silver treatment, *American Journal of Infection Control*: 26(6):572-577. **2.** Wright JB, *et al.* (1998) Efficacy of topical silver against fungal burn wound pathogens, *American Journal of Infection Control* (1999); 27(4): 344-350. **3.** Driffield K. ACTICOAT FLEX 3 has antimicrobial activity in 30 minutes. Data on file 0810018, Smith+Nephew. **4.** Driffield K. ACTICOAT FLEX 7 has antimicrobial activity in 30 minutes. Data on file 0810014, Smith+Nephew. **5.** Gago M, *et al.* (2008) A comparison of Three Silver – containing dressings in the treatment of infected, *Chronic Wounds* 20(10): 273-278. **6.** Westaim Report Ref. #010322. Seven day efficacy of ACTICOAT 7 Dressings against multiple organisms. **7.** Driffield K. Antimicrobial activity of ACTICOAT FLEX 7 against a broad spectrum of wound pathogens. Data on file 0810012, Smith & Nephew. **8.** Driffield K. Antimicrobial activity of ACTICOAT FLEX 7 dressings in a seven-day repeat challenge. Data on file 0810013, Smith+Nephew. **9.** Westaim Report Ref: # 971030. The antimicrobial activity of westaim's ACTICOAT Silver Coated Dressing against clinically relevant organsisms over an extended period of time. **10.** Driffield K. Antimicrobial activity of ACTICOAT FLEX 3 against a broad spectrum of wound pathogens. Data on File reference 0810016. **11.** Driffield K. Antimicrobial activity of ACTICOAT FLEX 3 in a three-day repeat challenge. Data on file 0810017, Smith+Nephew. **12.** Upton D. (2010) Pain and stress as contributors to delayed wound healing. *Wound Practice and Research*. **13.** Westaim (Sherritt) Report Ref: 93/001. Broad Spectrum Efficacy. **14.** Daubney L. Silver release testing of ACTICOAT FLEX 7 Dressings. Report reference DS/08/062/R2. **15.** Daubney, L: Silver Release Testing of ACTICOAT FLEX 3 Dressings. Report reference DS/08/078/R2.

ACTICOAT◊ Dressings
Two week challenge

Antimicrobial dressings recommended for 2 week duration initially

After 2 weeks re-evaluate patient, wound (A,B,C) and D treatment

- Discontinue anitmicrobial if clinical signs of infection (CSI) resolved and wound is progressing
- Continue with antimicrobial if wound is progressing but there are still CSI
- Consider an alternative antimicrobial if no improvement

4 of 4

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Consider the use of DURAFIBER® Ag Silver Gelling Fibre Dressing for deep infected wounds
†Unless iodine contraindicated CSI – Clinical signs of infection, BBWC = Biofilm based wound care, Schultz 2017
‡CSI = Clinical signs of infection

DURAFIBER Ag

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IODOSORB◊
0.9% Cadexomer Iodine Dressings

- IODOSORB Dressings, with cadexomer smart microbead technology, have been shown to physically disrupt mature biofilm[1-7]
- IODOSORB Dressings' dual action can breach the biofilm's protective matrix and kill the bacteria within[1,2,4,5,8-10]
- Meta-analysis of RCT level data highlights that cadexomer iodine generates higher healing rates than standard care in venous leg ulcers[11,12]

IODOSORB: efficacy backed by evidence

1. Fitzgerald DJ, Renick PJ, Forrest EC, *et al*. Cadexomer iodine provides superior efficacy against bacterial wound biofilms *in vitro* and *in vivo*. *Wound Repair Regen*. 2017;25(1):13–24. **2.** Phillips PL, Yang Q, Davis S, *et al*. Antimicrobial dressing efficacy against mature *Pseudomonas aeruginosa* biofilm on porcine skin explants. *Int Wound J*. 2015;12(4):469–483. **3.** Schultz G, Qingpin Y. Microbicidal effects of three daily treatments of a Carboxymethylcellulose Silver Dressing or a Cadexomer Iodine on mature bactericidal biofilms grown on pig skin explants. 2016; Florence. **4.** Roche ED, Woodmansey EJ, Yang Q, *et al*. Cadexomer iodine effectively reduces bacterial biofilm in porcine wounds *ex vivo* and *in vivo*. *Int Wound J*. 2019;1–10 [in press]. **5.** Akiyama H, Oono T, Saito M, Iwatsuki K. Assessment of cadexomer iodine against *Staphylococcus aureus* biofilm *in vivo* and *in vitro* using confocal laset scanning microscopy. *The Journal of Dermatology*. 2004;31:529–534. **6.** Lantis JC. Cadexomer iodine on a biofilm in diabetic foot ulcers: A Pilot study. Paper presented at: WUWHS; 2016; Florence. **7.** Forrest EC, Gunning P, Coleman D, Fitzgerald DJ. Cadexomer iodine delivers rapid and sustained broad spectrum antimicrobial activity and substantial biofilm disruption and kill in a clinicall revelant wound model. Paper presented at: EWMA; 2019; Gothenburg, Sweden. **8.** Oates JL, Phillips CD, Wolcott R, Woodmansey E. Effect of a Cadexomer Iodine wound dressing on a chronic wound multi-species biofilm model with comparison to a silver hydrofiber antibiofilm dressing. 2016. **9.** Hill KE, Malic S, Mckee R, *et al*. An *in vitro* model of chronic wound biofilms to test wound dressings and assess antimicrobial susceptibilities. *J Antimicrob Chemother*. 2010;65(6):1195–1206. **10.** Kiamco MM, Atci E, Mohamed A, Call DR, Beyenal H. Hyperosmotic agents and antibiotics affect dissolved oxygen and pH concentration gradients in *Staphylococcus aureus* biofilms. *Appl Environ Microbiol*. 2017;83(6). **11.** O'Meara S, Al-Kurdi D, Ologun Y, Ovington LG, Martyn-St James M, Richardson R. Antibiotics and antiseptics for venous leg ulcers (Review). Cochrane Database of Systematic Reviews. 2014(Issue 1 Art. No.: CD003557). **12.** O'Meara S, Al-Kurdi D, Ologun Y, Ovington LG. Antibiotics and antiseptics for venous leg ulcers (Review). Cochrane Database of Systematic Reviews. 2010(Issue 1 Art. No.: CD003557).

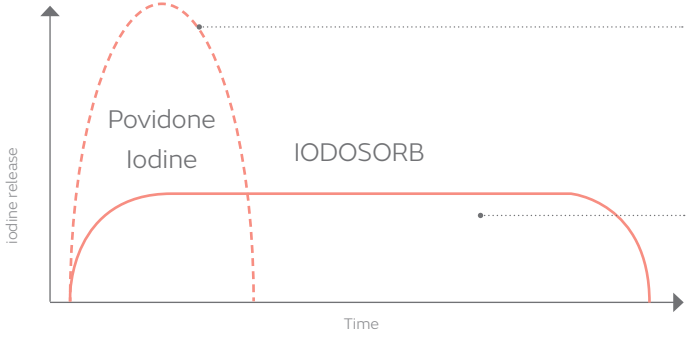
IODOSORB◊
0.9% Cadexomer Iodine Dressings

IODOFLEX◊
0.9% Cadexomer Iodine Pad

Cadexomer smart micro-bead technology

IODOSORB is a novel antimicrobial dressing made of cadexomer smart micro-beads. Spherical starch structures loaded with 0.9% elemental iodine.

The iodine is physically bound to the bead and is only released when the bead comes into contact with wound fluid.[1-3]



For illustration purposes, not based on actual data.

Older iodine formulations such as Povidone Iodine deliver high and short-lived doses[4]

Cadexomer smart micro-bead technology harnesses the effectiveness of iodine by delivering it in effective, sustained low concentrations[1-3]

1. Skog E, *et al. Br. J. Dermatol* (1983); 109, 77–83. **2.** Smith+Nephew data on file (2009); #0804006. **3.** Smith+Nephew data on file (2009); #091101. **4.** Hendley JO, *et al.* Antimicrob. Agents Chemother (1991); 35, 627–631.

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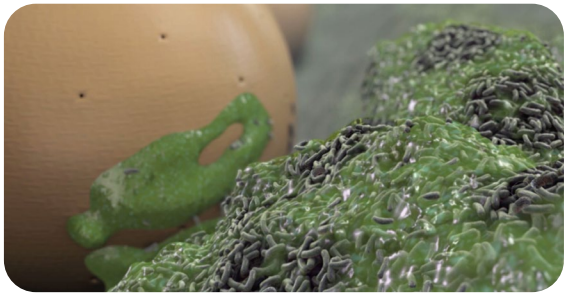
IODOSORB◊
0.9% Cadexomer Iodine Dressings

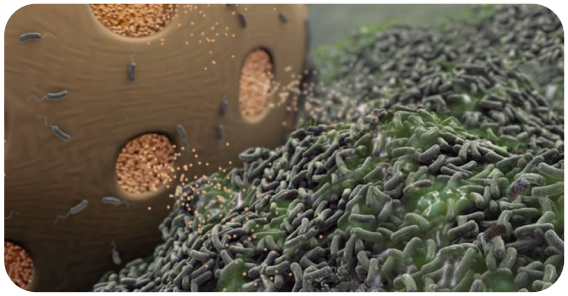
IODOFLEX◊
0.9% Cadexomer Iodine Pad

Anti-biofilm mode of action



It is suggested that the cadexomer micro-beads are able to dehydrate and directly destroy the biofilm structure.[1]

Dual action to disrupt biofilm[1-7]



Once the cadexomer beads are able to breach the biofilm-specific matrix, the iodine can subsequently kill the exposed bacteria within the biofilm community.[1]

The unique dual action of IODOSORB is particularly effective in the disruption of biofilm:[1-7]

1. High absorptive property

- Dehydration of the biofilm matrix[2]
- Desloughing action[8-9]
- Promotes autolytic debridement[10]

2. Antimicrobial 0.9% Iodine

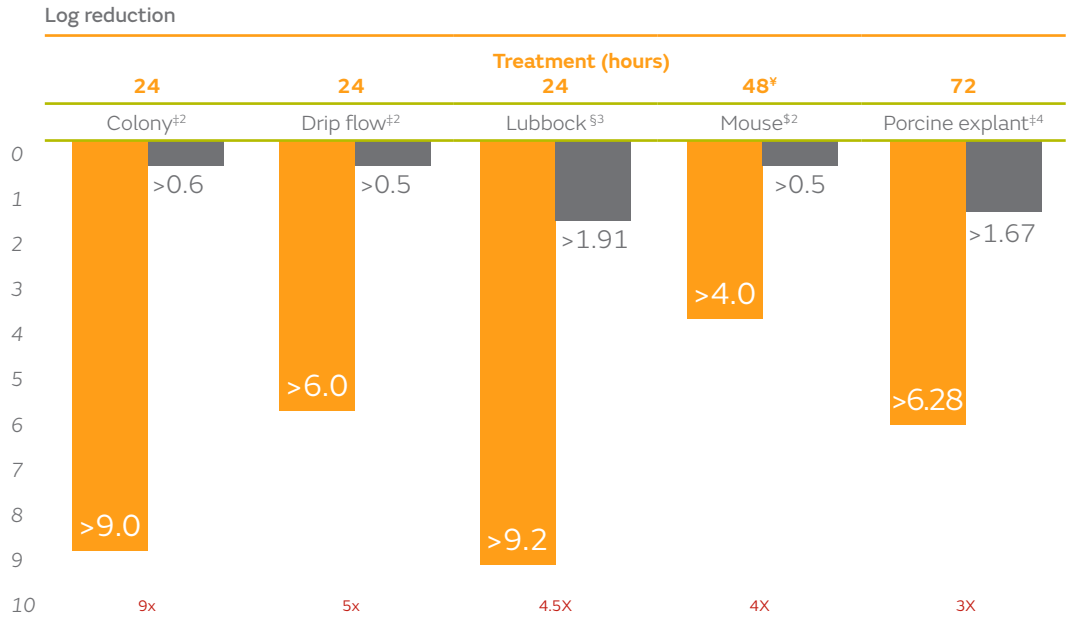
- Killing the exposed biofilm bacteria[2]
- Sustained gentle release of iodine[11,12]
- Broad spectrum antimicrobial efficacy[13-15]

1. Roche ED, Woodmansey EJ, Yang Q, *et al.* Cadexomer iodine effectively reduces bacterial biofilm in porcine wounds *ex vivo* and *in vivo*. *Int Wound J.* 2019;1-10 [in press]. **2.** Akiyama H, Oono T, Saito M, Iwatsuki K. Assessment of Cadexomer Iodine against *Staphylococcus aureus* biofilm *in vivo* and *in vitro* using confocal laset scanning microscopy. *The Journal of Dermatology.* 2004;31:529-534. **3.** Fitzgerald DJ, Renick PJ, Forrest EC, *et al.* Cadexomer iodine provides superior efficacy against bacterial wound biofilms *in vitro* and *in vivo*. *Wound Repair Regen.* 2017;25(1):13-24. **4.** Phillips PL, Yang Q, Davis S, *et al.* Antimicrobial dressing efficacy against mature *Pseudomonas aeruginosa* biofilm on porcine skin explants. *Int Wound J.* 2015;12(4):469-483. **5.** Oates JL, Phillips CD, Wolcott R, Woodmansey E. Effect of a Cadexomer Iodine wound dressing on a chronic wound multi-species biofilm model with comparison to a silver hydrofiber antibiofilm dressing. 2016. **6.** Hill KE, Malic S, Mckee R, *et al.* An *in vitro* model of chronic wound biofilms to test wound dressings and assess antimicrobial susceptibilities. *J Antimicrob Chemother.* 2010;65(6):1195-1206. **7.** Kiamco MM, Atci E, Mohamed A, Call DR, Beyenal H. Hyperosmotic agents and antibiotics affect dissolved oxygen and pH concentration gradients in *Staphylococcus aureus* biofilms. *Appl Environ Microbiol.* 2017;83(6). **8.** Ormiston MC, Seymour MTJ, Venn GE, Cohen RI, Fox JA. Controlled trial of IODOSORB in chronic venous ulcers. *British Medical Journal.* 1985;291:308-310. **9.** Hansson C, Persson L-M, Stenquist B, *et al.* The effects of cadexomer iodine paste in the treatment of venous leg ulcers compared with hydrocolloid dressing and paraffin gauze dressing. *International Journal of Dermatology.* 1998;37 (390-396). **10.** Troeng T, Skog E, Arnesjo B, *et al.* A randomised multicentre trial to compare the efficacy of cadexomer iodine and standard treatment in the management of chronic venous ulcers in out-patients. Stuttgart: Schattauer Verlag; 1983. **11.** Skog E, Arnesjo B, Troeng T, *et al.* A randomized trail comparing cadexomer iodine and standard treatment in the out-patient management of chronic venous ulcers. *British Journal of Dermatology.* 1983;109:77-83. **12.** Smith+Nephew data on file 2009; #091101. **13.** Gottardi W. Disinfection, sterilization and preservation (ed. Block, S. S.) 152–166 (Lea and Febiger, 1991). **14.** Cooper RA. Iodine revisited. *Int Wound J.* 4, 124–37 (2007). **15.** Johnson A. A combative healer with no ill-effect IODOSORB in the treatment of infected wounds. *Prof. Nurse* 7, 60, 62, 64 (1991).

Superior efficacy against biofilm proven across different lab models[1-4]

IODOSORB◊ has a long history of effectiveness against biofilm with superior results compared to other topical antimicrobials such as PHMB, silver and povidone iodine.

In line with the biofilm experts' recommendations on selecting an effective anti-biofilm dressing, IODOSORB has been tested and shown to be more effective than Aquacel™ Ag+ across five challenging and clinically relevant biofilm models.[1-3]



Superior effect of IODOSORB against *in vitro* and in animal biofilm models compared to many other topical antimicrobials[1]

‡ *Staphylococcus aureus* mature biofilms; $ MRSA biofilms; § Mixed bacterial cultures. *Pseudomonas aeruginosa* PA01, *Staphylococcus aureus* Mu50, and *Enterococcus faecalis* V583; ¥ Treatment every 24 h for 48 h total. **1.** Phillips, *et al. Int W J.* 12: 469-83 (2013). **2.** Fitzgerald DJ, *et al. Wound Repair Regen.* 25: 13-24 (2016). **3.** Oates JL, *et al.* Poster presented at SAWC, Atlanta. (2016). **4.** Schultz G, Yang. Poster presented at WUWHS Florence (2016) N.B. Values in red indicate the number of times more effective IODOSORB was demonstrated to be compared to Aquacel™ Ag+ in that test model.

Why silver is less effective against biofilm

Charged ions, such as silver or chlorides are more easily neutralised by the Extracellular Polymeric Substance matrix.[5]

Moreover the concentration of silver required to eradicate biofilm is estimated to be 10 to 100 times higher than that used to eradicate planktonic bacteria.[6] Such concentrations are currently unavailable in any silver dressing.

1. Fitzgerald DJ. *et al. Wound Repair Regen.* 1–40 (2016). **2.** Schultz G, Yang. Poster presented at WUWHS Florence (2016). **3.** Akiyama H, *et al. J. Dermatol.* 31, 529–34 (2004). **4.** Hill E, *et al. J Antimicrob. Chemother.* 1195-1206 (2010). **5.** Zhou LH, *et al. Br. J. Dermatol.* 146, 365–74 (2002). **6.** O'Meara S, *et al.* Cochrane database Syst. Rev. 1, CD003557 (2014).

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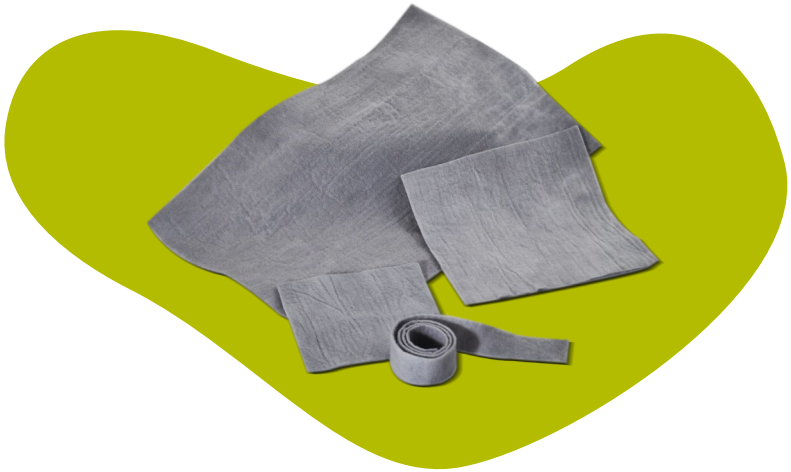
DURAFIBER◊ Ag

Strength in performance and design

20% + 80% = 100%

Natural strengthening cellulose fibres + Gelling cellulose ethyl sulphonate fibres (CES) = Finely spun matrix that forms a soft cohesive gel on contact with exudate



Indications

DURAFIBER Ag is designed to be left in place for up to 7 days.[1-3]
It can be applied to chronic and acute wounds including:

- Leg ulcers
- Pressure ulcers
- Diabetic foot ulcers
- Surgical wounds
- Traumatic wounds
- Tunnelling wounds
- Partial thickness burns
- Wounds prone to bleeding following debridement

DURAFIBER Ag Range

1. Smith+Nephew Wound Management Laboratory report, reference DS/15/269/R, DURAFIBER Ag (Recipe E) Testing. Dowler A. December 2015. **2.** Forlee M, Rossington A, Searle R. A prospective, open, multicentre study to evaluate a new gelling fibre dressing containing silver in the management of venous leg ulcers. *Int. Wound J.* 2014;11(4):438-45. **3.** Smith+Nephew Wound Management laboratory report, reference DS/12/093/DOF, Integrity Testing of DURAFIBER Ag in horse serum and ionic solution, Dowler A, April 2012.

in different markets. Not all products referred to may be approved for use or available in all markets. Please consult your local Smith+Nephew representative for further details on products available in your market. Intended for healthcare professionals outside of the US only.

*Consider the use of DURAFIBER® Ag Silver Gelling Fibre Dressing for deep infected wounds
†Unless iodine contraindicated CSI – Clinical signs of infection, BBWC = Biofilm based wound care, Schultz, 2017
‡CSI = Clinical signs of infection

DURAFIBER Ag

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DURAFIBER◊ Ag

Designed with patients in mind

Some wounds require a dressing that is effective, easy to apply, and comfortable for the patient

Fast and highly absorptive properties[1,2]

- Absorbs[1,2] and retains[5] fluid even under compression
- Locks exudate[1,3,6] and any pathogenic bacteria[7] into the dressing
- Silver technology with antimicrobial activity[8-10]
- Minimal Shrinkage[1-2] to conform intimately[11] to the wound bed[3,12]

Designed for optimal patient comfort

- Comfortable for the patient[3]
- Fast gelling[1,2] provides a cool feeling when in contact with fluid[3]
- Easy to apply[3]
- Intact one-piece removal thanks to its high wet tensile strength[1-4]

Fast acting

- DURAFIBER Ag has been demonstrated to start killing pathogens within 30 minutes[13] of contact and to possess an antimicrobial activity, effective for up to 7 days.[8]

1. Smith+Nephew Wound Management laboratory report, reference DS/16/341/R. Analytical and physical properties of DURAFIBER Ag Recipe E. Giaffar L, October 2016. **2.** Smith+Nephew Wound Management laboratory report, reference DS/15/269/R. DURAFIBER Ag (Recipe E) Testing. Dowler A, December 2015. **3.** Forlee M, Rossington A, Searle R. A prospective, open, multicentre study to evaluate a new gelling fibre dressing containing silver in the management of venous leg ulcers. *Int. Wound J.* 2014;11(4):438-45. **4.** Smith+Nephew Wound Management laboratory report, reference DS/12/093/DOF. Integrity testing of DURAFIBER Ag in horse serum and ionic solution. Dowler A, April 2012. **5.** Smith+Nephew Wound Management laboratory report, reference DS.16.443.R. DURAFIBER Ag Recipe E absorption during compression. Giaffar L, November 2016. **6.** Smith+Nephew Wound Management laboratory report, reference DS/12/158/R2. Sequestration testing of DURAFIBER Ag. Lidster C, April 2014. **7.** Smith+Nephew Wound Management, data on file report, reference 1412017. Visual demonstration of sequestration of *Pseudomonas aeruginosa* and *Staphylococcus aureus* in a DURAFIBER Ag dressing using confocal microscopy. Lumb H, December 2014. **8.** Smith+Nephew Wound Management data on file report, reference 1510009. Antimicrobial activity of DURAFIBER Ag against bacteria, yeast and fungi commonly found in wounds over a 7 day period. Lumb H, October 2015. **9.** Smith+Nephew Wound Management, data on file report, reference 1510008. Antimicrobial activity of DURAFIBER Ag against a broad spectrum of wound pathogens. Lumb H, October 2015. **10.** Smith+Nephew Wound Management data on file report, reference 15010010. Antimicrobial activity of DURAFIBER Ag against bacteria, yeast and fungi commonly found in wounds over a 4 hour period. Lumb H, October 2015. **11.** Smith+Nephew Wound Management laboratory report, reference DS/12/143/R2. Intimate contact testing of DURAFIBER Ag. Lidster C, April 2014. **12.** Barrett S, *et al.* Case series evaluation: The use of DURAFIBER on exuding wounds. *Wounds UK* 2012, Volume 8, No 3. **13.** Smith+Nephew Wound Management, data on file report, reference 1609013. Assessment of the contact kill activity of DURAFIBER Ag against common wound pathogens. Lumb H, September 2016.

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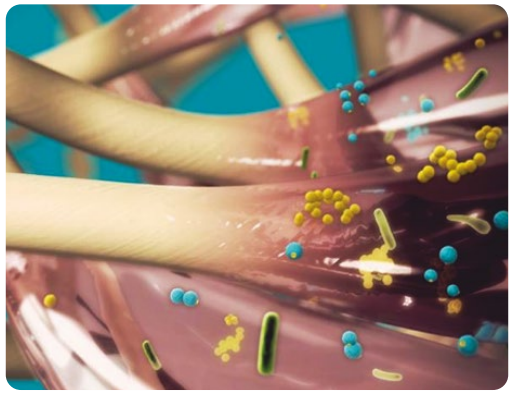
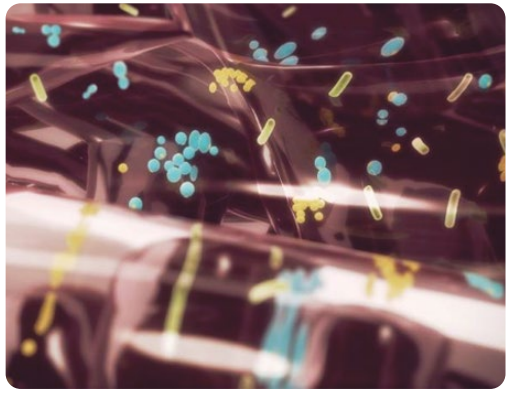
DURAFIBER◊ Ag
Silver gelling mode of action

When DURAFIBER Ag comes into contact with exudate, the individual fibres hydrate and swell as they absorb wound fluid, forming a soft, cohesive gel sheet.[1,2] As the fibres swell they lock in the absorbed exudate[4] and the silver-containing gelled dressing matrix provides an antimicrobial action proven (*in vitro*) effective against a broad spectrum of bacteria including Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Pseudomonas aeruginosa*.[6-8]

Before application



Forming a gel upon contact with exudate[3]



Locks in exudate[1,3,4] and harmful bacteria[5] it may contain

1. Smith+Nephew Wound Management laboratory report, reference DS/16/341/R. Analytical and physical properties of DURAFIBER Ag Recipe E. Giaffar L, October 2016. **2.** Smith+Nephew Wound Management laboratory report, reference DS/15/269/R. DURAFIBER Ag (Recipe E) Testing. Dowler A, December 2015. **3.** Forlee M, Rossington A, Searle R. A prospective, open, multicentre study to evaluate a new gelling fibre dressing containing silver in the management of venous leg ulcers. *Int. Wound J.* 2014;11(4):438-45. **4.** Smith+Nephew Wound Management laboratory report, reference DS/12/158/R2. Sequestration testing of DURAFIBER Ag. Lidster C, April 2014. **5.** Smith+Nephew Wound Management data on file report, reference 1412017. Visual demonstration of sequestration of *Pseudomonas aeruginosa* and *Staphylococcus aureus* in a DURAFIBER Ag dressing using confocal microscopy. Lumb H, December 2014. **6.** Smith+Nephew Wound Management data on file report, reference 1510009. Antimicrobial activity of DURAFIBER Ag against bacteria, yeast and fungi commonly found in wounds over a 7 day period. Lumb H, October 2015. **7.** Smith+Nephew Wound Management data on file report, reference 1510008. Antimicrobial activity of DURAFIBER Ag against a broad spectrum of wound pathogens. Lumb H, October 2015. **8.** Smith+Nephew Wound Management data on file report, reference 15010010. Antimicrobial activity of DURAFIBER Ag against bacteria, yeast and fungi commonly found in wounds over a 4 hour period. Lumb H, October 2015.

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6. The clear choice
A pathway to guide

YES
Consider high performance dressings

Evaluate contributary underlying factors – is the wound healing?
- Despite successful TIM no reduction in wound size / surface by >5% / week

NO
Consider NPWT
Action: specialist

ALLEVYN◊ LIFE
Foam Dressings

- ALLEVYN LIFE Dressings can be worn almost twice as long as standard dressings*[1]
- Advanced exudate lock-in, designed to help minimise leakage[4,5]
- Retained 1.9 times the amount of exudate, compared to Mepilex™ Border Flex when the dressing was compressed[6,7†]

Unique five-layer design

- Shower-proof,‡ highly breathable film[2,8]
- Built-in discretion (EXUMASK◊ masking layer)[3]
- Highly absorbent, lock-away layer with EXULOCK◊ Advanced Lock-in[4]
- Hydrocellular foam
- Silicone adhesive wound contact layer[5]

1 of 2

*n=37; dressing retention was 1.92x longer. †Demonstrated in vitro. n=30, p<0.001. ‡Do not immerse the dressing in water

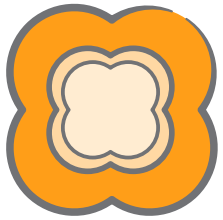
1. Joy H, *et al.* A collaborative project to enhance efficiency through dressing change practice. *Journal of Wound Care* 2015;24(7):312,314-7. **2.** Smith+Nephew 2015. Laboratory report GMCA-DOF-08 - HVT080_ST970. **3.** Smith+Nephew Data on File DS/16/061R. Mumby, E. February 2016. **4.** Smith+Nephew data on file DS/15/025/R. Daubney L, May 2016. **5.** Smith & Nephew data on file DS/14/303R. Earl K, April 2016. **6.** Data on File Report DS/19/071R - ALLEVYN LIFE absorbency evaluation. March 2019. **7.** Data on File Report DS/19/072R - Mepilex™ Border Comfort/ Mepilex™ Border Flex absorbency evaluation. March 2019.‡ **8.** Smith & Nephew 8 June 2016. Permeability of ydrophillic Polyurethane Film when in contact with water and water vapour (ALLEVYN LIFE). Internal report. RD/16/019.

It is the responsibility of healthcare professionals to determine and utilise the appropriate products and techniques according to their own clinical judgment for each of their patients.

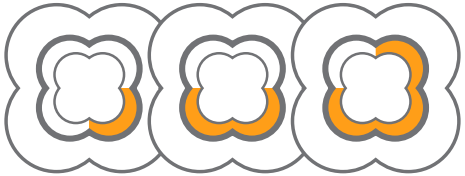
6. The clear choice

A pathway to guide

Improved patient confidence while saving you time[1-9*]



Unique quadrilobe shape combined with the wide border securely fits to the contours of the body, reassuring patients that the dressing will stay in place[1,2]



EXUMASK◊ Change Indicator lets you and your patients know the best time to change the dressing[2-4]

EXULOCK◊ Advanced Lock-in technology minimises dressing leakage and provides odour control,[5-8] helping it to last longer than other foam dressings[9†]

*Compared to standard care. † n=37; dressing retention was 1.92x longer.

1. Rossington A, Drysdale K, Winter R. Clinical performance and positive impact on patient wellbeing of ALLEVYN LIFE. *Wounds UK*. 2013;9(4):91–95. **2.** Stephen-Haynes J, Bielby A, Searle R. The clinical performance of a silicone foam in an NHS community trust. *Journal of Community Nursing*. 2013;27(5):50–59. **3.** Simon D, Bielby A. A structured collaborative approach to appraise the clinical performance of a new product. *Wounds UK*. 2014;10(3):80–87. **4.** Smith+Nephew February 2016 2016.Subjective comparison of masking ability of the new ALLEVYN LIFE versus current ALLEVYN LIFE by healthcare professionals. Internal report. DS/16/061/R. **5.** Smith+Nephew May 2016 2016. New ALLEVYN LIFE Gen2 wcl - Physical testing. Internal report. DS/15/025/R. **6.** Smith+Nephew 20 June 2016. A randomised cross-over clinical evaluation to compare performance of ALLEVYN LIFE and Mepilex® Border dressings on patient wellbeing-related endpoints. Internal report. CE/047/ALF. **7.** Grothier L. Gentle foam dressings: interim results of an evaluation of the ALLEVYN range. *British journal of nursing* 2009;18(11):S12, S14, S16 passim. **8.** Smith+Nephew 14 June 2012. Odour reducing properties of ALLEVYN LIFE. Internal report. DS/12/127/DOF. **9.** Joy H, Bielby A, Searle R. A collaborative project to enhance efficiency through dressing change practice. *J Wound Care*. 2015;24(7):312, 314–317.

6. The clear choice
A pathway to guide

YES
Consider high performance dressings

Evaluate contributary underlying factors – is the wound healing?
- Despite successful TIM no reduction in wound size / surface by >5% / week

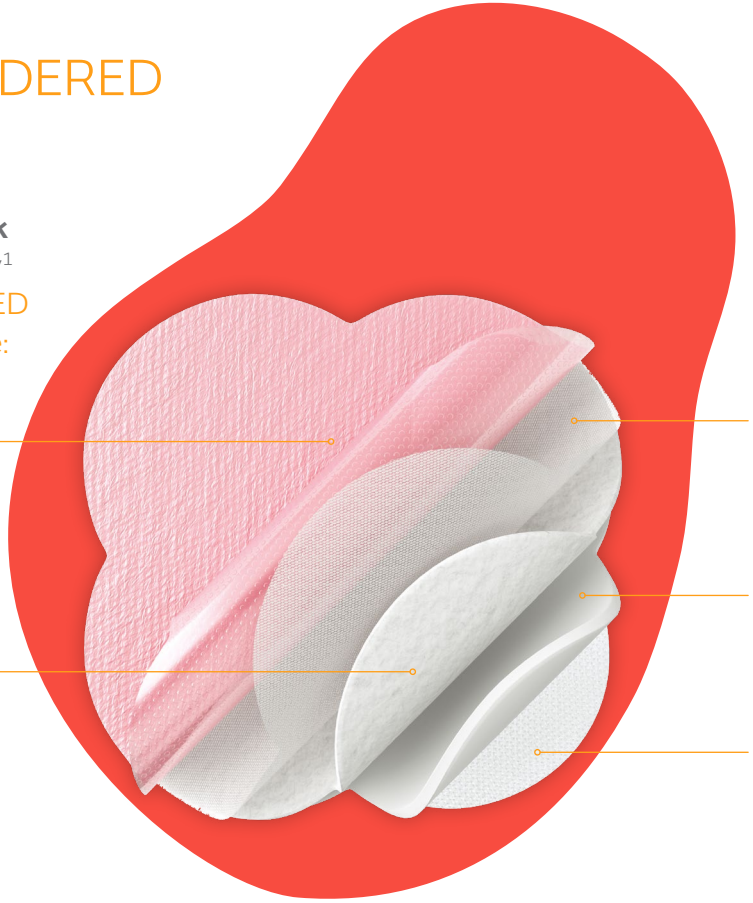
NO
Consider NPWT
Action: specialist

ALLEVYN◊ LIFE NON-BORDERED
Foam Dressing

Five-layer structure designed with **fluid lock technology** to absorb, then lock-in instantly[1]
Each layer of ALLEVYN LIFE NON-BORDERED Dressings is designed with a specific purpose:

Opaque pink film helps **prevent bacterial strikethrough**[4]* and is waterproof[5]

Hyper-absorbent fleece layer **locks-in fluid**,† reducing risk of leakage[2,3]



Polyethylene net provides **structure and integrity** for the dressing

2mm layer of ALLEVYN polyurethane foam **moves fluid away from wound and peri-wound** into lock-away layer[3]

Perforated silicone wound contact layer is **suitable for fragile skin**[6,7]

*Demonstrated *in vitro* over a 24 hr period. †As demonstrated in benchtop testing.

1. Smith+Nephew R&D Report Version 2 WMP/13/507 – Technical description of dressing mode of action of ALLEVYN LIFE NON-BORDERED. **2.** Smith+Nephew data on file DS17.530.R. Comparison of fluid absorption under compression between ALLEVYN LIFE NON-BORDERED and Mepilex™ XT Smith+Nephew data on file DS.16.334 v2 ALLEVYN LIFE NON-BORDERED fluid uptake testing. **3.** Rossington A, *et al.* Clinical performance and positive impact on patient wellbeing of ALLEVYN LIFE. *Wounds UK* 2013;9(4):91–5. **4.** Data on file 1611018 (2016). Bacterial barrier testing of ALLEVYN LIFE NON-BORDERED using modified wet/dry conditions. **5.** Smith+Nephew data on file DS.16.328.R ALLEVYN LIFE NON-BORDERED physical testing. 2017. **6.** Smith+Nephew 2019. A Pilot randomized controlled trial to evaluate and advanced borderless dressing (ALLEVYN LIFE NON-BORDERED) in the treatment of chronic ulcers. Internal report. CT1603ALF. **7.** Vowden K. An open, prospective randomised, multi-centre clinical evaluation of a hydrocellular silicone foam dressing* in the management of exuding chronic and acute wounds. Paper presented at EWMA; 2011; Brussels.

6. The clear choice
A pathway to guide

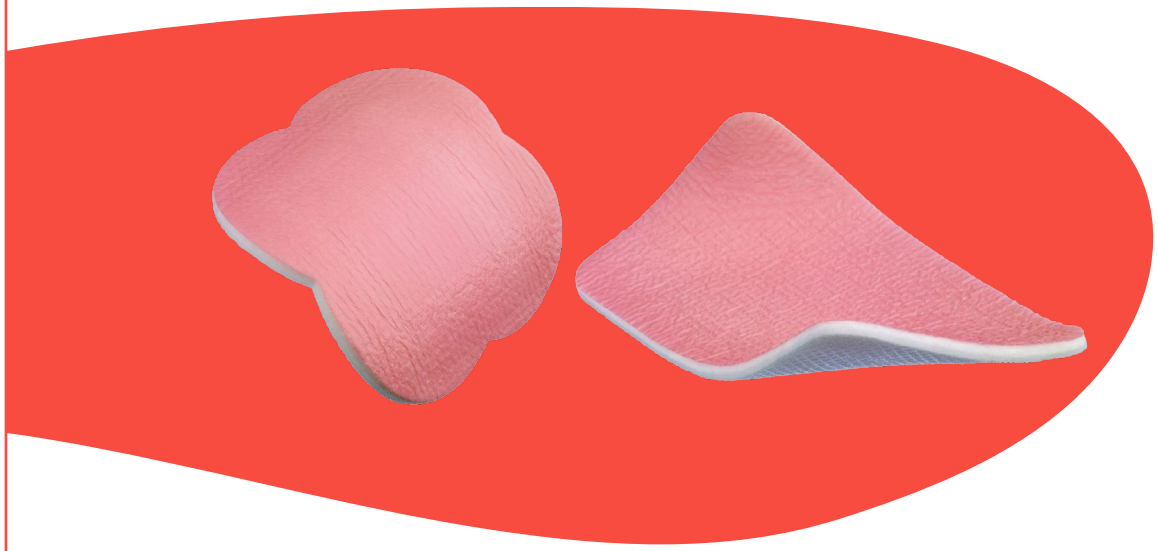
YES
Consider high performance dressings

Evaluate contributary underlying factors – is the wound healing?
- Despite successful TIM no reduction in wound size / surface by >5% / week

NO
Consider NPWT
Action: specialist intervention

ALLEVYN◊ LIFE NON-BORDERED
Foam Dressing

Designed for vertical absorption,* even under compression[1]



Maintains absorption under compression
Minimises the amount of fluid released from the dressing under compression[1,2]

Highly absorbent
The hyper-absorbent lock-away layer helps to minimise the leakage of fluid[2,3]

Vertical absorption
Equivalent absorption in horizontal and vertical orientations[1,3]

Silicone adhesive
Silicone adhesive minimises the trauma to the wound and pain to the patient during dressing changes[4,5]

Can be cut to size[6]

2 of 2

*Based on proven performance on wound model data

1. Smith+Nephew 2016. Wound model of ALLEVYN LIFE NON-BORDERED Dressings - 7 day vertical testing on a curved plate under compression bandaging with horse serum using a flow rate modelling that of a moderately exuding wound. Internal report. DS/16/469/R. **2.** Smith+Nephew 2016. ALLEVYN LIFE NON-BORDERED - Physical testing. Internal report. DS/16/328/R. **3.** Smith+Nephew 2016. Wound model of ALLEVYN LIFE NON-BORDERED Dressings - 7 day horizontal testing with horse serum using a flow rate modelling that of a moderately exuding wound. Internal report. DS/16/470/R. **4.** Smith+Nephew 2019. A pilot randomized controlled trial to evaluate and advanced borderless dressing (ALLEVYN LIFE NON-BORDERED) in the treatment of chronic ulcers. Internal report. CT1603ALF. **5.** Vowden K. An open, prospective randomised, multi-centre clinical evaluation of a hydrocellular silicone foam dressing* in the management of exuding chronic and acute wounds. Paper presented at EWMA; 2011; Brussels. **6.** Smith+Nephew 2016. Shedding when cut - Testing of ALLEVYN LIFE NON-BORDERED and DURAFIBER◊ dressings. Internal report. DS/16/429/R.

ALLEVYN◊ GENTLE BORDER

Foam Dressing:

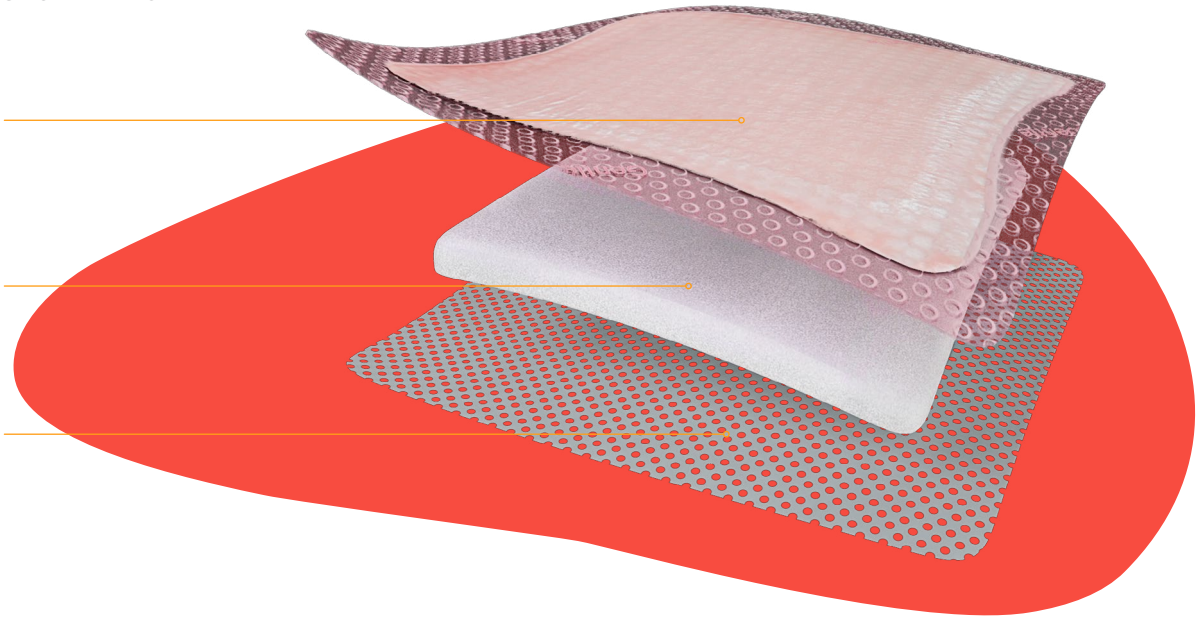
Each layer of ALLEVYN GENTLE BORDER Dressings is designed with a specific purpose:

Triple-layer dressing, designed with the patient in mind

Breathable top film to create a moist wound healing environment for optimum wound healing[1-4]

Hydrocellular foam core pad to absorb exudate[5]

Wound contact layer with **soft silicone adhesive** for easy application[1,6,7] and minimising pain and trauma for the patient on removal[1,8]



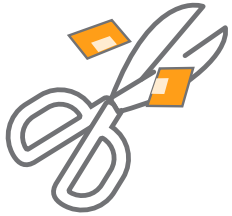
1. Hurd T, Gregory L, Jones A, Brown S. A multi-centre in-market evaluation of ALLEVYN GENTLE BORDER. *Wounds UK*. 2009;5(3):32–44. **2.** Smith+Nephew 2016. ALLEVYN GENTLE BORDER Heel Gen 2 - Physical evaluation. Internal report. DS/16/465/R. **3.** Smith+Nephew 2017. ALLEVYN GENTLE BORDER Gen 2 - Physical evaluation. Internal report. DS/16/424/R V3. **4.** Smith+Nephew 2019. Use of Moisture Vapour Permeability (MVP) and Moisture Vapour Transmission Rate (MVTR) data to support product claims referring to moist wound healing. Internal report. EO.AWM.PCSgen.001.v2. **5.** Smith+Nephew data on file report DS/09/013/R2. Daubney L, May 2009. **6.** Grothier L. Gentle foam dressings: interim results of an evaluation of the ALLEVYN range. *British Journal of Nursing* 2009;18(11):S12, S14, S16 passim. **7.** Callaghan R, Chadwick P, Mahoney K, Stephen-Haynes J.Case series evaluation: The use of ALLEVYN GENTLE BORDER multisite on chronic wounds. *Wounds UK*. 2012;8(4):110–118. **8.** Vowden K, *et al*. An open, prospective randomised, multi-centre clinical evaluation of a hydrocellular silicone foam dressing in the management of exuding chronic and acute wounds. Poster presented at EWMA 2011.

6. The clear choice

ALLEVYN◊ GENTLE BORDER

Foam Dressings: Proven to minimise dressing changes and contribute to patient quality of life[1-4]

Adaptability offered through a wide range of shapes and sizes to accommodate multiple wound needs



Easy to cut* to size, without shedding, adding further flexibility[5]

Multi-way stretch helps with awkward and mobile locations[6-9]

Gentle gel silicone minimises pain during dressing changes[3,6]

*The bacterial properties of the dressing will be compromised if it is cut

1. Grothier L. GENTLE Foam Dressings: interim results of an evaluation of the ALLEVYN range. *British Journal of Nursing* 2009;18(11). **2.** Vowden K, *et al.* An open, prospective randomised, multi-centre clinical evaluation of a hydrocellular silicone foam dressing in the management of exuding chronic and acute. Poster presented at EWMA 2011. **3.** Callaghan R, *et al.* Case series evaluation: The use of ALLEVYN GENTLE BORDER Multisite on chronic wounds. *Wounds UK* 2012;8(4). **4.** Smith+Nephew data on file,report DS/09/013/R2. Daubney L, May 2009. **5.** Smith+Nephew data on file, report DS/14/318/R. Blackburn I, January 2015. H2011. **6.** Hurd T, *et al.* A multi-centre in-market evaluation of ALLEVYN GENTLE BORDER. *Wounds UK* 2009;5(3):32-44. **7.** Smith & Nephew 2016. ALLEVYN GENTLE BORDER Heel Gen 2 - physical evaluation. Internal report. DS/16/465/R. **8.** Smith & Nephew 2017. ALLEVYN GENTLE BORDER Gen 2 - Physical evaluation. Internal report. DS/16/424/R V3. **9.** Rafter L, Reynolds T, Rafter M. An audit of patient outcomes in the management of skin tears using silicone dressings. *Wounds UK*. 2016;12(2):70-78.

6. The clear choice
A pathway to guide

YES
Consider high performance dressings

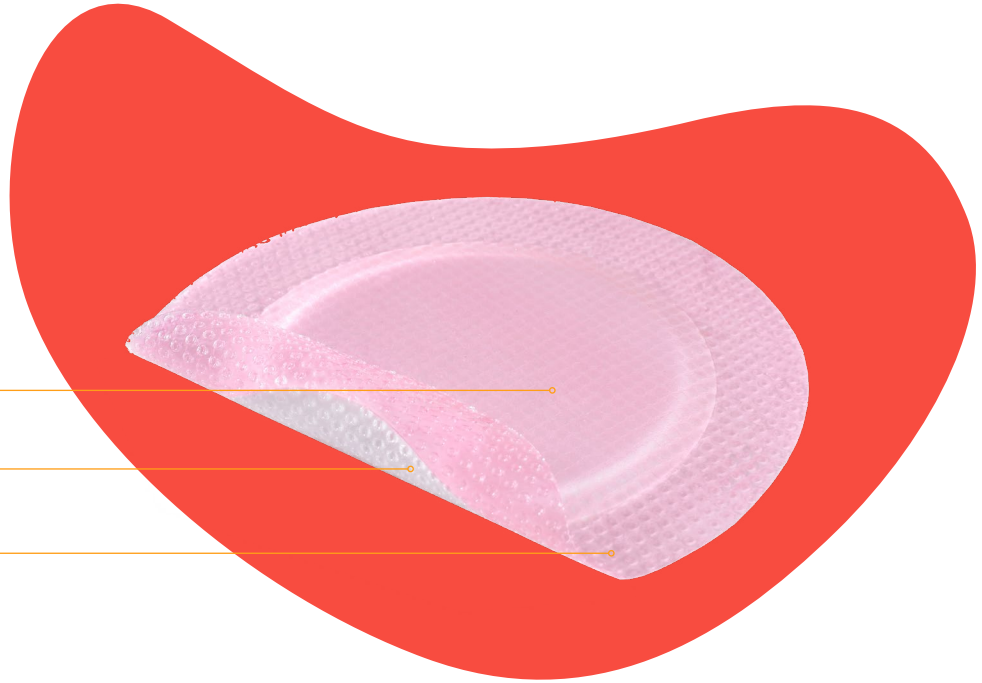
Evaluate contributary underlying factors – is the wound healing?
- Despite successful TIM no reduction in wound size / surface by >5% / week

NO
Consider NPWT
Action: specialist intervention

ALLEVYN◊ GENTLE BORDER LITE
Foam Dressing:
Suitable for fragile skin[1,2] and hard-to-dress areas[1,3]

Highly conformable[1,4] triple-layer dressing

- Easily moulds to body contours and hard-to-dress areas such as the nose, neck, shoulder, finger, hand, heel and abdomen[1,3]
- Suitable for use on sensitive and fragile skin with soft adhesive to help minimise pain on removal[5,6]



1. Stephen-Haynes J, Greenwood, M. Clinical evaluation of ALLEVYN GENTLE BORDER LITE within one health trust. *British Journal of Nursing*. 2011;20(20):36–42. **2.** Denyer JE. Wound management for children with epidermolysis bullosa. *Dermatol Clin*. 2010;28(2):257–ix. **3.** Dharma H. An open, prospective, randomized, within volunteer, comparison of ALLEVYN GENTLE BORDER and Mepilex™ Border. Smith & Nephew Medical Ltd., Hull. OR-DOF/011, 24 August 2010. **4.** Stephen-Haynes J. Clinical and financial outcomes with ALLEVYN GENTLE BORDER LITE◊. *Wounds UK*, 2011;7(2):94–100. **5.** Hurd T, Gregory, L., Jones, A., Brown, S. A multi-centre in-market evaluation of ALLEVYN GENTLE BORDER. *Wounds UK*. 2009;5(3):16–28. **6.** Vowden K, Moiemen N, Drysdale K. An open, prospective randomised, multi-centre clinical evaluation of a hydrocellular silicone foam dressing* in the management of exuding chronic and acute wounds. EWMA; 2011; Brussels. **7.** Tompkins L. ALLEVYN GENTLE BORDER LITE Dressing physical properties. Smith & Nephew Medical Ltd., Hull. DS/10/100/R1. August 2010.

It is the responsibility of healthcare professionals to determine and utilise the appropriate products and techniques according to their own clinical judgment for each of their patients.

ALLEVYN◊ GENTLE
Foam Dressing

Breathable top film[1]

- Waterproof[1]
- Aids in the prevention of fluid and bacterial strikethrough*[1,2]
- Switches to become more permeable in the presence of fluid[1]

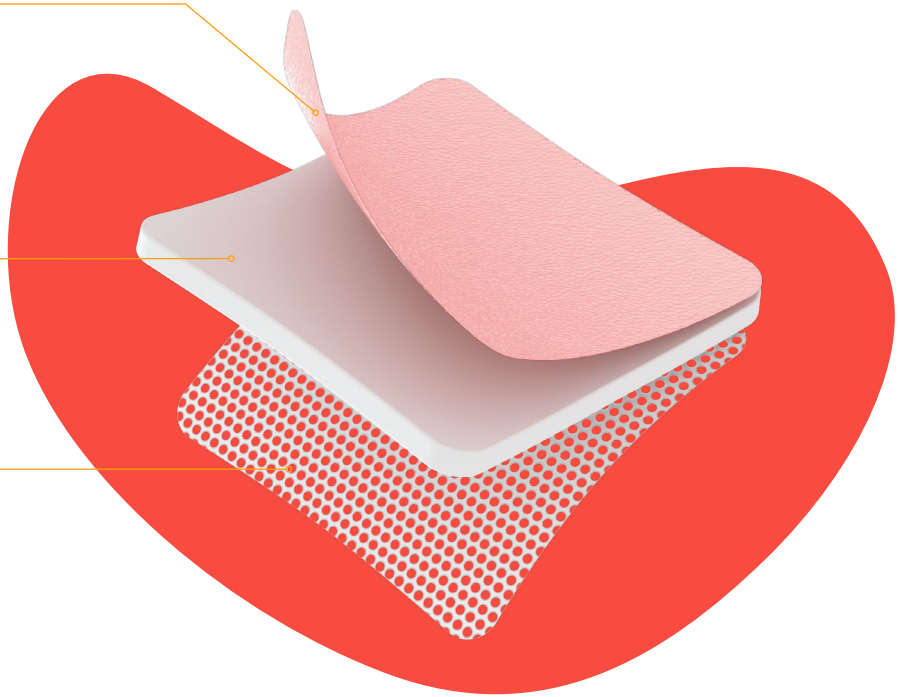
Soft[3] Hydrocellular

ALLEVYN foam layer

- Highly absorbent[1,4]

Gentle[5-7] silicone adhesive

- Is designed for use on fragile skin[6,7]
- Holds the dressing in place while bandaging[8,9]
- Enables easy repositioning without losing its adherent properties[8,9]
- Minimises trauma to the wound and pain to the patient during dressing changes[9,10]

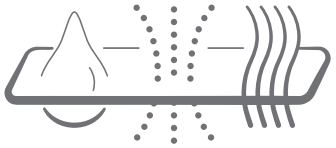


*As demonstrated *in-vitro*

1. Smith+Nephew 2019. New ALLEVYN GENTLE with silicone wound contact layer – Physical properties. Internal report. RD/19/083/V2. **2.** Smith+Nephew 2019. Bacterial barrier testing of Peridot ALLEVYN GENTLE Dressing verification batches under wet/wet conditions. Internal report. MB-TM001-29-R. **3.** Smith+Nephew 2018. Volunteer evaluation of AWM product features. Internal report. EO.AWM.PCSgen.005.v1. **4.** Benbow M. Exploring the concept of moist wound healing and its application in practice. *British Journal of Nursing*. 2008;17 (Tissue Viability Supplement)(15):S4 - S16. **5.** Smith+Nephew 2019. ALLEVYN GENTLE 2 vs ALLEVYN GENTLE – horizontal wound model using viscous SWF at a flow rate modelling that of a moderately exuding wound. Internal report. DS/19/054/R. **6.** Rafter L, Reynolds T, Rafter M. An audit of patient outcomes in the management of skin tears using silicone dressings. *Wounds UK*. 2016;12(2):70–78. **7.** Carter J. The use of a silicone adhesive dressing (ALLEVYN GENTLE BORDER) on a patient with extremely fragile skin. Paper presented at: Wounds UK; 2008; Harrogate, UK. **8.** Smith+Nephew 2014. An open, prospective, randomized volunteer trial to assess the retention qualities of 4 non-bordered silicone foam dressings under secondary retention. Internal report. VTR/HVT079/ST965. **9.** Vowden K. An open, prospective randomised, multi-centre clinical evaluation of a hydrocellular silicone foam dressing* in the management of exuding chronic and acute wounds. Paper presented at: EWMA; 2011; Brussels. **10.** Hurd T, Gregory L, Jones A, Brown S. A multi-centre in-market evaluation of ALLEVYN GENTLE BORDER. *Wounds UK*. 2009;5(3):32-44.

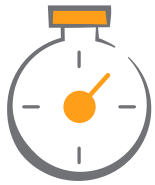
ALLEVYN◊ GENTLE
Foam Dressing

Designed for fragile skin,[1,2] its soft silicone gel makes the dressing suitable even for delicate and fragile skin.[1,2] This holds the dressing in place while bandaging[2] and helps minimise pain during dressing changes[3,4]



With highly absorbent properties,[5,6] it can absorb exudate, even viscous,*[7] and maintains absorption under compression*[5,8]

Versatile to meet your needs,[8,9] it is cuttable,[8] soft,[10] conformable[5,8] to body contours[5,11]* and with multi-way stretch[9].This makes it suitable for multiple wound types and suitable for awkward areas and mobile locations[9]



Promotes fast healing by maintaining a moist wound environment[5,12-14]

*As demonstrated *in-vitro*.

1. Rafter L, Reynolds T, Rafter M. An audit of patient outcomes in the management of skin tears using silicone dressings. *Wounds UK*. 2016;12(2):70–78. **2.** Carter J. The use of a silicone adhesive dressing (ALLEVYN GENTLE BORDER) on a patient with extremely fragile skin. Paper presented at: Wounds UK; 2008;Harrogate, UK. **3.** Vowden K. An open, prospective randomised, multi-centre clinical evaluation of a hydrocellular silicone foam dressing* in the management of exuding chronic and acute wounds. Paper presented at: EWMA; 2011; Brussels. **4.** Hurd T, Gregory L, Jones A, Brown S. A multi-centre in-market evaluation of ALLEVYN GENTLE BORDER. *Wounds UK*. 2009;5(3):32–44. **5.** Smith+Nephew 2019. New ALLEVYN GENTLE with silicone wound contact layer – Physical properties. Internal report. RD/19/083/V2. **6.** Benbow M. Exploring the concept of moist wound healing and its application in practice. *British Journal of Nursing*. 2008;17 (Tissue Viability Supplement)(15):S4–S16. **7.** Smith+Nephew 2019. ALLEVYN GENTLE 2 vs ALLEVYN GENTLE – horizontal wound model using viscous SWF at a flow rate modelling that of a moderately exuding wound. Internal report. DS/19/054/R. **8.** Smith & Nephew 2019. Project Peridot (ALLEVYN GENTLE V2 with Alston Silicone WCL) Non-specification physical testing for verification. Internal report. DS/19/058/R. **9.** Smith & Nephew 2019.ALLEVYN GENTLE 2 - Extensibility testing. Internal report. DS/19/198/R Version 2. **10.** Smith & Nephew 2018. Volunteer evaluation of AWM product features. Internal report. EO.AWM.PCSgen.005.v1. **11.** Smith & Nephew 2019. ALLEVYN GENTLE 2 - Vertical wound model using horse serum at a flow rate modelling that of a moderately exuding wound using a compression bandage system. Internal report. DS/19/197/R. **12.** Smith & Nephew 2019. ALLEVYN GENTLE 2 - Horizontal wound model testing using horse serum at a flow rate modelling that of a moderately exuding wound for up to 7 days. Internal report. DS/19/191/R. **13.** Smith & Nephew 2019. ALLEVYN GENTLE 2 - Horizontal wound model testing using horse serum at a flow rate modelling that of a highly exuding wound. Internal report. DS/19/196/R Version 2. **14.** Smith & Nephew 2019. Use of Moisture Vapour Permeability* (MVP) and Moisture Vapour Transmission Rate* (MVTR) data to support ALLEVYN GENTLE (Project Peridot) providing a moist wound environment which is optimal for healing. Internal report. EO.AWM.PCS263.001.v1.

6. The clear choice

A non-adherent hydrogel that rehydrates necrotic tissue, promoting autolytic debridement.[1-9]

✓	**Effective debridement and desloughing[3,10]** Effective rehydrating action can produce debridement of necrotic tissue[2-6] whilst preserving the surrounding viable skin.[3,5,10]
✓	**Easy application[3,6,11]** The unique APPLIPAK◊ system provides simple, directable and controlled application.[3,6,11]
✓	**Autolytic debridement can be carried out by any clinician**

Also available as INTRASITE CONFORMABLE
Conformable Hydrogel Dressing

1. Jones A, Vaughan D. Hydrogel dressings in the management of a variety of wound types: A review. *Journal of Orthopaedic Nursing*. 2005;9. **2.** Smith+Nephew 2011.Physical and chemical properties of INTRASITE Gel APPLIPAK. Internal report. DS/11/008/R4. **3.** Colin D, Kurring Pa, Yvon C. Managing sloughy pressure sores. *J Wound Care*. 1996;5(10):444–446. **4.** Cassino R, Ricci E, Carusone A. A conformable hydrogel in the debridement of complex necrotic wounds. Paper presented at: EWMA; 1997; Milan. **5.** Smith+Nephew 2020. Use of literature and data to support the INTRASITE Mode of Action. Internal report. EO.AWM.PCSgen.004.v2. **6.** Flanagan M. The efficacy of a hydrogel in the treatment of wounds with non-viable tissue. *Journal of Wound Care*. 1995;4(6):264–7. **7.** Thomas S, Fear M. The efficacy of INTRASITE gel as a debrider of non-viable tissue from wounds treated in the community. Paper presented at: EWMA; 1993; Harrogate, UK. **8.** Thomas S, Fear M. Comparing two dressings for wound debridement. *Journal of Wound Care*. 1993;2(5):272–274. **9.** Williams C. Intrasite Gel: a hydrogel dressing. *British journal of nursing* (Mark Allen Publishing). 1994;3(16):843–846. **10.** Bale S, Banks V, Haglestein S, Harding KG. A comparison of two amorphous hydrogels in the debridement of pressure sores. *Journal of Wound Care*. 1998;7(2):65-68. **11.** Smith+Nephew. A pilot study comparing INTRASITE GEL with saline soaked gauze for debridement. Internal report. CTR90/08. **12.** Young T, Williams C, Benbow M, *et al*. A study of two hydrogels used in the management of pressure sores. Proceedings of the Sixth European Conference on Advances in Wound Management; 1997; London. **13.** Smith+Nephew 2018. Simulated in-use testing, transparency testing and dilution testing of INTRASITE GEL. Internal report U/004/R1.

The products used in the T.I.M.E. clinical decision support tool may vary in different markets. Not all products referred to may be approved for use or available in all markets. Please consult your local Smith+Nephew representative for further details on products available in your market. Intended for healthcare professionals outside of the US only.

Smith+Nephew does not provide medical advice. The information presented is not, and is not intended to serve as, medical advice. For detailed device information, including indications for use, contraindications, precautions and warnings, please consult the product's Instructions for Use (IFU) prior to use. It is the responsibility of healthcare professionals to determine and utilise the appropriate products and techniques according to their own clinical judgment for each of their patients.

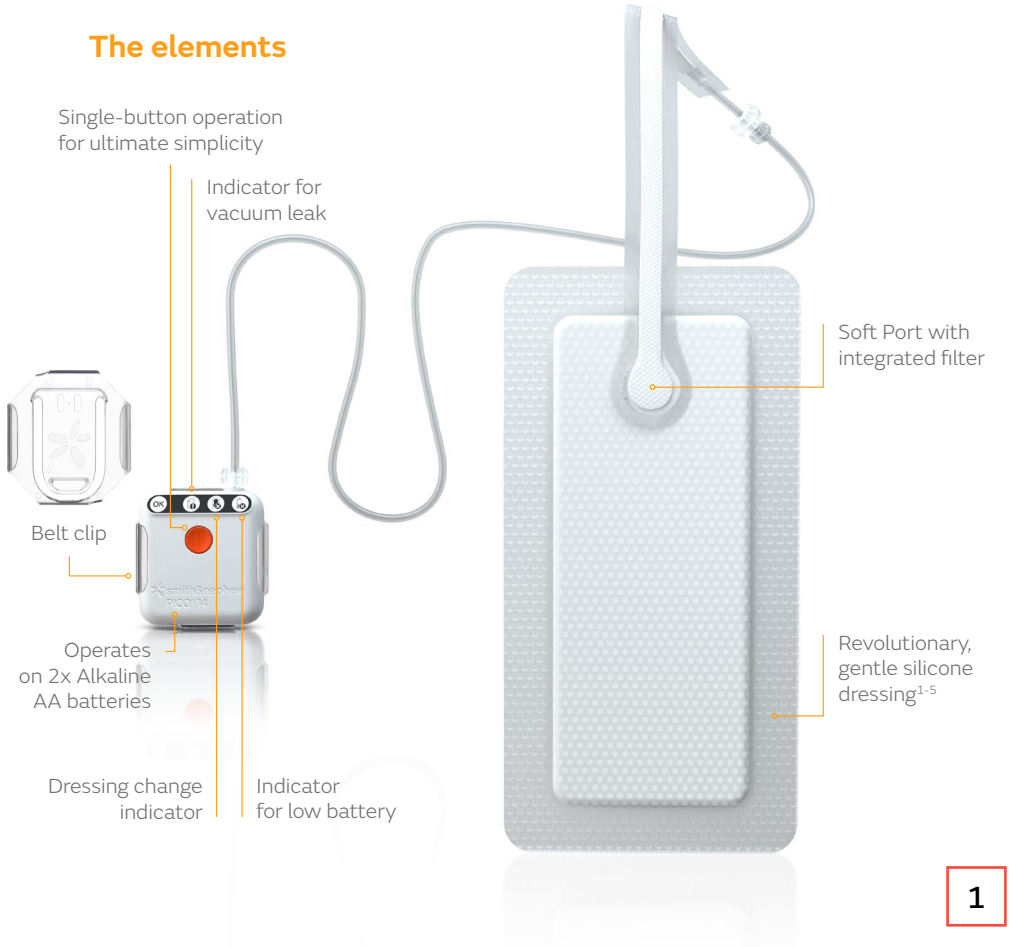
DURAFIBER◊
Gelling Fibre Dressing

- Highly absorbent[1-5]
- Retains/locks in fluid, even under compression[1,4-8]
- Minimises risk of pooling[1,5,6,8-10]
- Reduces dead space where bacteria may proliferate[4,11,12]
- DURAFIBER conforms intimately to the wound bed[5,7]
- DURAFIBER is soft and highly conformable[2,13]
- Intact, one-piece removal[1,2,4,14-16]
- Can be left in place for up to seven days

1. Smith & Nephew 2010. DURAFIBER Dressing physical properties. Internal report. DS/10/056/R1. **2.** Barrett S, Callaghan R, Ivins N, Stephen-Haynes J. Case series evaluation: the use of DURAFIBER on exuding wounds. *Wounds*. 2012;8(3):104–113. **3.** Davies A, Harish S, Price J. Selecting dressings to manage exudate and enhance patient wellbeing. *Wounds UK*. 2015;11(3):54–61. **4.** Smith & Nephew 2015. DURAFIBER Ag Recipe E testing. Internal report. DS/15/269/R. **5.** Smith & Nephew 2016. Analytical and physical properties of DURAFIBER Ag Recipe E. Internal report. DS/16/341/R. **6.** Smith & Nephew 2014. Testing of the absorption of DURAFIBER and Aquacel™ while the dressing is under compression. Internal report. DS/10/037/R1. **7.** Smith & Nephew 2010. Report of testing on lateral wicking of DURAFIBER versus Aquacel™ and Kaltostat™ dressings. Internal report. DS/10/042/R1. **8.** Smith & Nephew 2016. DURAFIBER Ag (Recipe E): Absorption during compression. Internal report. DS/16/443/R. **9.** Smith & Nephew 2012. Wound model testing of DURAFIBER with various secondary dressings. Internal report. DS/12/314/R. **10.** Smith & Nephew 2014. Wound model testing of DURAFIBER Ag Dressings with various secondary dressings. Internal report. DS/10/053/R2. **11.** Dowler A. Testing performed as part of DURAFIBER photo shoot. October 2011. Laboratory report DS/11/187/DOF. **12.** Woodmansey E. The potential for proliferation of bacteria in wound exudate. RR-WMPO6290-40-01 04 2010. **13.** Smith & Nephew 2011. Testing performed as part of DURAFIBER photo-shoot. Internal report. DS/11/187/DOF. **14.** Forlee M, Rossington A, Searle R. A prospective, open, multicentre study to evaluate a new gelling fibre dressing containing silver in the management of venous leg ulcers. *Int Wound J*. 2014;11(4):438–445. **15.** Smith & Nephew 2012. Integrity testing of DURAFIBER Ag in horse serum and ionic solution. Internal report. DS/12/093/DOF. **16.** Bullough L, Fumerola S, Forster E, Ivins N, Timmons J. A small multicentre evaluation of a new gelling fibrous silver dressing. *JCN*. 2015;29(2):34–40.

PICO◊ 14 and AIRLOCK◊ Technology dressing

The elements



AIRLOCK Technology for effective outcomes

Only **PICO** sNPWT has a proprietary **AIRLOCK** Technology layer

1. **Silicone adhesive layer** minimises pain on removal[1-5]
2. **Pioneering AIRLOCK Technology** transmits pressure evenly across the whole wound bed and surrounding zone of injury*[6,10]
3. **Super absorbent core** locking exudate away from wound*[6,7]
4. **Top film layer** has a high moisture vapour transmission rate and protects the wounds from external contamination*[8,9]
5. **PICO** Soft Port with integrated filter[11]

On average,
80%
of the exudate is lost by evaporation[6*]

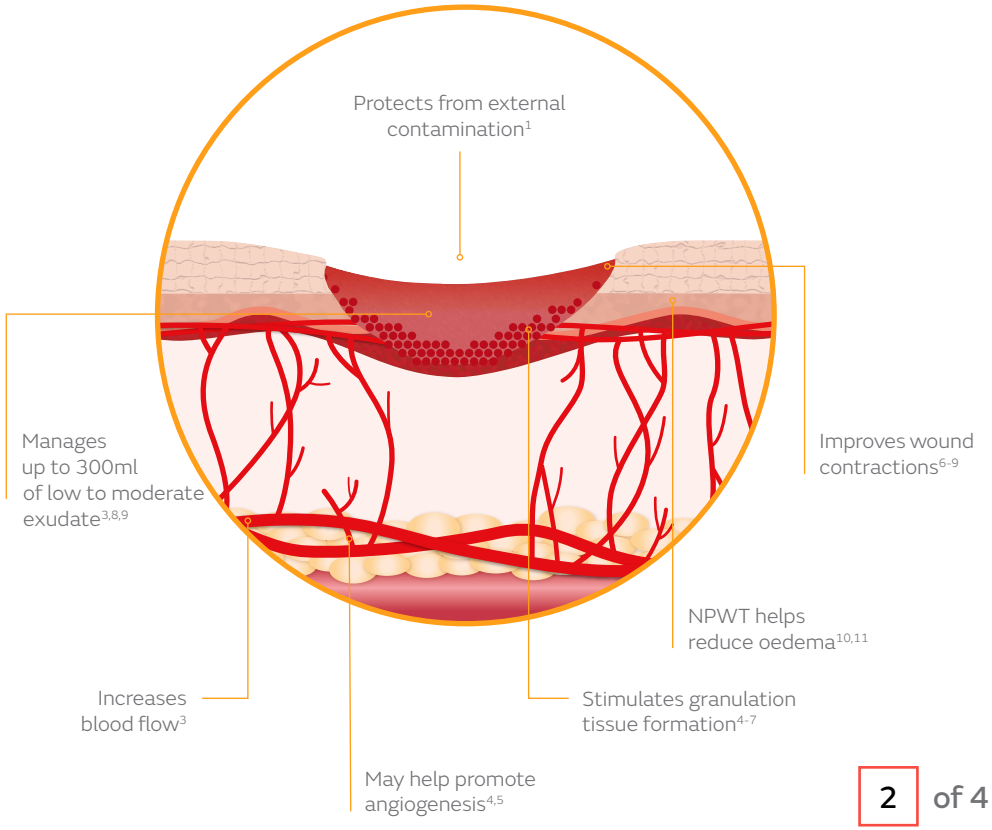
Approximately,
20%
fluid still remains in the dressing[6*]

*_In-vitro_ testing.

1. Hudson DA, Adams KG, Van Huyssteen A, Martin R, Huddleston EM. Simplified negative pressure wound therapy: clinical evaluation of an ultraportable, no-canister system. *Int Wound J.* 2015;12(2):195–201. **2.** Payne C, Edwards D. Application of the single Use Negative Pressure Wound Therapy device (PICO) on a heterogeneous group of surgical and traumatic wounds. *ePlasty.* 2014:152–166. **3.** Smith & Nephew May 2015. A prospective, open, non-comparative, multi-centre study to evaluate the functionality and dressing performance of a new negative pressure enhanced dressing (NPED) in acute wounds (CT09/02). Internal report. ST865 CT09/02. **4.** Sharp E. Single use NPWT for the treatment of complex orthopaedic surgical and trauma wounds. *Journal of Wound Care.* 2013;22(10):S5-S9. **5.** Stryja J, Staffa R, Říha D, Stryjová K, Nicielniková K. Cost-effectiveness of negative pressure wound therapy in outpatient setting. *Prolekare.* 2015. **6.** Malmsjo M, *et al.* Biological effects of a disposable, canisterless negative pressure wound therapy system. *ePlasty.* 2014;14:113-127. **7.** Smith+Nephew 2019. Summary report of *in vitro* wound model and negative pressure delivery (nominal -80mmHg) testing for PICO v2 (PICO 7 and PICO 14) System. Internal report. RD/18/134 V2. **8.** Smith & Nephew 2018. Summary of rountine QA testing on MVP of PICO Dressings. 2018. Internal report. DS/18/153/R. **9.** Lumb H. Data on file report.1102010. April 2011. **10.** Smith +Nephew 2019. PICO biomechanical study. Internal report. DS/19/211/R. **11.** Smith+Nephew 2018. PICO Soft Port Dressing Filter. Internal Report. RD.18.078.v1.

PICO◊ System

Mechanism of action (MoA)



- Protects from external contamination, acting as a bacterial barrier and locking bacteria away[1]
- Improves perfusion[2,3] via increase in blood flow[3] versus tNPWT
- Promotes micro-deformation, facilitating the generation of granulation tissue[4-7]
- Supports macro-deformation, facilitating wound contraction[4-7]
- Manages low to moderate exudate up to 300ml[3,8,9]
- NPWT helps reduce oedema[10,11]
- NPWT promotes lymphatic drainage[12]

1. Lumb H. Bacterial barrier testing (wet-wet) of PICO Dressing with a 7 day test duration against *S. marcescens*. February 2011 (*In-vitro*). Data on file report 1102010. **2.** Dowsett C, Huddleston E, Milne J. Reducing the burden of chronic wounds in the community with single-use NPWT Using disposable negative (2015). **3.** Malmsjö M, *et al.* Biological effects of a disposable, canisterless Negative Pressure Wound Therapy system. *ePlasty* 2014;14:e15. **4.** Dunn R, Hurd T, Chadwick P, *et al.* Factors associated with positive outcomes in 131 patients treated with gauze-based negative pressure wound therapy. *Int J Surg*. 2011;9(3):258–262. **5.** Young SR, Hampton S, Martin R. Non-invasive assessment of negative pressure wound therapy using high frequency diagnostic ultrasound: oedema reduction and new tissue accumulation. *Int Wound J*. 2013;10(4):383–388. **6.** Brownhill VR, Huddleston E, Bell A, *et al.* Pre-clinical assessment of single-use negative pressure wound therapy during *in vivo* porcine wound healing. *Adv Wound Care*. 2020 Jul 7. [Epub ahead of print]. **7.** Kirsner R, Dove C, Reyzelman A, Vayser D, Jaimes H. A Prospective, Randomised, controlled clinical trial on the efficacy of a single-use negative pressure wound therapy system, compared to traditional negative pressure wound therapy in the treatment of chronic ulcers of the lower extremities. *Wound Repair and Regeneration*. 2019;27(5):519–529. **8.** Roberts S. *In-vitro* wound model testing of PICO at a moderate exudate flow rate, March 2011. Data on file reference DS/11/037/R2. **9.** Roberts S. *In-vitro* wound model testing of PICO at a low exudate flow rate, April 2011. Data on file reference DS/11/057/R2. **10.** Kamolz LP, Andel H, Haslik W, *et al.* Use of subatmospheric pressure therapy to prevent burn wound progression in human: first experiences. *Burns*. 2004;30(3):253–258. **11.** Birke-Sorensen H, Malmsjo M, Rome P, *et al.* Evidence-based recommendations for negative pressure wound therapy: treatment variables (pressure levels, wound filler and contact layer)- steps towards an international consensus. *J Plast Reconstr Aesthet Surg*. 2011;64 Suppl:S1–16. **12.** Kilpadi DV, Cunningham MR. Evaluation of closed incision management with negative pressure wound therapy (CIM): hematoma/seroma and involvement of the lymphatic system. *Wound Repair Regen*. 2011;19(5):588-596.

It is the responsibility of healthcare professionals to determine and utilise the appropriate products and techniques according to their own clinical judgment for each of their patients.

PICO◊ System
Clinical evidence

Kick start or accelerate healing in stalled wounds

The use of PICO System on stalled chronic wounds of diverse aetiology has been shown to:

- Reduce wound size by an average of 21% (one-fifth) each week[2]*
- Heal chronic wounds on average 10 weeks earlier than predicted with standard wound care dressings[2]*
- Heal chronic wounds six times faster than predicted with standard dressings[1,2]*†

On a 12-week treatment period for Venous Leg Ulcer and Diabetic Foot Ulcer wounds over four weeks old, PICO has been shown to:

- Significantly reduce wound area and depth compared to tNPWT[3] (Figures 1 and 2)‡
- Have an average wear time of 6.5 days for PICO dressings vs. 3.1 days for tNPWT[3]
- Be more than twice as effective at achieving wound closure than traditional Negative Pressure Wound Therapy (tNPWT) (45% vs. 22.2%)[3]

Figure 1. Wound area

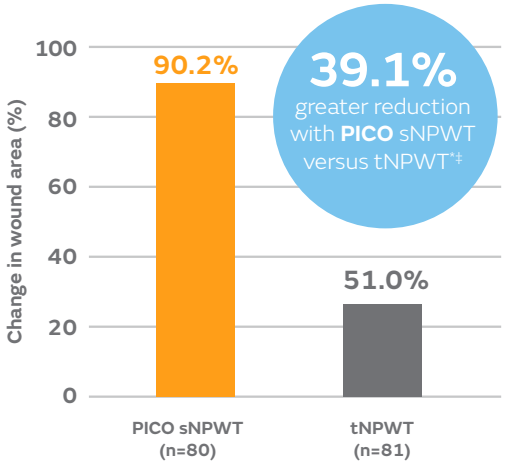


Figure 2. Wound depth

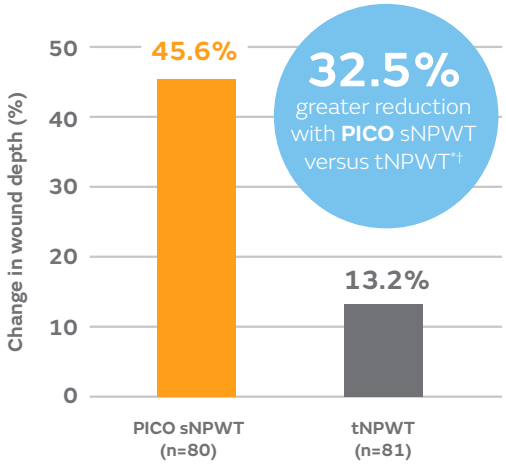
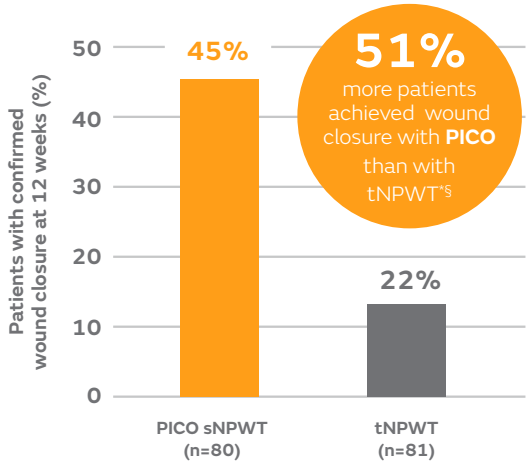


Figure 3. Wound closure



*Based on 5 out of 9 wounds responding; wound mean duration prior to study 44 week, study size n=9. †A prospective cohort study of 52 wounds, PICO healed wounds n=14. ‡These statistics come from two patient populations, which include outliers in the dataset.

1. Dowsett C, Hampton J, Myers D, Styche T. Use of PICO to improve clinical and economic outcomes in hard-to-heal wounds. *Wounds International*. 2017;8, p53–58. **2.** Hampton J. Providing cost-effective treatment of hard-to-heal wounds in the community through use of NPWT. *Br J Community Nurs*, 2015. Suppl Community Wound Care:S1, S16–20. (13). **3.** Kirsner R, Dove C, Reyzelman A, Vayser D, Jaimes H. A prospective, randomised, controlled clinical trial on the efficacy of a single-use negative pressure wound therapy system, compared to traditional negative pressure wound therapy in the treatment of chronic ulcers of the lower extremities. *Wound Repair and Regeneration*. 2019;27(5):519–529.

PICO◊ System
Clinical evidence

Healing rates following use of PICO System by wound duration[1]

Less than 3 months	3-6 months	6-12 months	Over 1 year

Intervention with Negative Pressure Wound Therapy (NPWT) can be a great option for wound closure in indicated types of wounds. However, the time of intervention is critical, as the longer the wait, the lower the healing rates.[1]

Early intervention. 94% success rate in healing with PICO◊

Healing rates were nearly **x3** better among wounds treated <3 months-old, compared with treating those >1 year-old[1*]

*n=52; 0-3 vs 12+ months starting wound duration

1. Dowsett C, Huddleston E, Milne J. Reducing the burden of chronic wounds in the community with single-use NPWT Using disposable negative (2015).

It is the responsibility of healthcare professionals to determine and utilise the appropriate products and techniques according to their own clinical judgment for each of their patients.

RENASYS◊ TOUCH Negative Pressure
Wound Therapy System

✓	Intuitive, user-friendly touchscreen interface for quick, easy-to-learn operation[1,2]
✓	Clinically effective for a range of chronic and acute wounds across a variety of care settings[3]
✓	Adjustable compression rate and variable intermittent mode allow for tailoring the therapy to an individual patient's needs and comfort[2]
✓	The leak gauge is designed to aid clinicians in locating and resolving air leaks[2]
✓	Easy-to-use onscreen quick reference guide supports device operation[2,4]
✓	Detailed pump activity log enables monitoring of patient concordance
✓	Up to 14 hours of battery life on a single charge[5]

1. Smith+Nephew 2016. Smith+Nephew's RENASYS TOUCH Device – User Validation. Internal report. DS/16/174/R. **2.** Forlee M, Richardson J. An interim analysis of device functionality and usability of RENASYS TOUCH - a new portable Negative Pressure Wound Therapy (NPWT) system. Paper presented at Wounds UK 2016. Harrogate, UK. **3.** Forlee M, Van Zyl L, Louw H, Nel J, Fourie N, Hartley R. A randomised controlled trial to compare the clinical efficacy and acceptability of adjustable intermittent and continuous Negative Pressure Wound Therapy (NPWT) in a new portable NPWT system. Paper presented at EWMA, 2018. Krakow, Poland. **4.** Smith+Nephew 2016. Smith+Nephew's RENASYS TOUCH Device Features – Software features. Internal Report. DS.16.179.R. **5.** Smith+Nephew 2018. Project Colne Verification of RENASYS TOUCH Connect device battery while in use. 21. DS.17.623.R V2.

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The next generation of traditional NPWT

Simple application and operation

97% of clinicians found it very easy to set up the pump and obtain a vacuum[1] (RCT, n=71)

Users resolved 93% of instances using on-board guidance[1]

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55% mean reduction in wound area[1] (p<0.001)

Significant improvement in the amount of healthy viable tissue and exudate levels[1] (p<0.001)

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The study concluded the two systems are comparable and equally efficacious in the treatment of complex wounds p>0.1364[1]

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65%	64%
RENASYS	V.A.C.™

% patients achieving their treatment goal was **similar for both groups:***

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*No statistical difference

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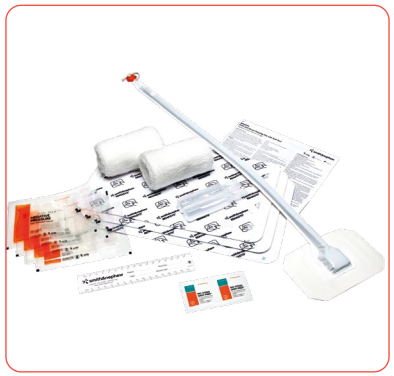
RENASYS◊ Dressing Kits and RENASYS Soft Port



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Choice and flexibility to ensure patient comfort and ease of application[1-2]

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1. Hurd T, Chadwick P, Cote J, Cockwill J, Mole T, Smith J. Impact of gauze based NPWT on the patient and nursing experience in the treatment of challenging wounds. 2010. *Int Wound J*. In Press. **2.** Bondojki, Samer DPM, *et al.* Clinical efficacy of an alternative foam-based Negative Pressure Wound Therapy system. Poster presented at The Symposium on Advanced Wound Care 2010. **3.** Carnali M, Ronchi R, Finocchi L, Spuri Capesciotti S, Paggi B. Retrospective study on the use of negative pressure wound therapy in the treatment of pilonidal cysts (sinus pilonidalis) operated on using an open technique or complicated by dehiscence of the surgery site through sepsis. *Acta Vulnologica*. Vol 14 2016:24–39. **4.** Smith & Nephew 2012. A prospective, open, non-comparative, multi-centre study to evaluate the functionality and device performance of a new Negative Pressure Wound Therapy (NPWT) suction port (RENASYS◊ Soft Port) in the management of acute, sub-acute and chronic wounds CSR/CT/US/11/01. **5.** Hudson D, Adams K, Cockwill J, Smith J. Evaluation of a new Negative Pressure Wound Therapy (NPWT) suction port (RENASYS Soft Port). Paper presented at: EWMA; 2013.

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PROSHIELD◊ Range

helping to maintain skin integrity

For use on intact and injured skin associated with incontinence[1-4]

Safe and effective

Safe and effective for the management of moisture related skin damage[3-5]

26% reduction

A study has observed a combined 26% reduction in the incidence of pressure ulcers and incontinence-associated dermatitis (IAD) when a comprehensive skin care regime*, including the PROSHIELD system, was implemented.*2

Prevent and protect

Helps prevent and protect skin from IAD and moisture lesions[1,3-5]

*Compared to prior standard of care

1. Flynn D, Williams S. Barrier creams for skin breakdown, *Nursing & Residential Care.* 2011; 13 (11): 553-558. **2.** Wall L, Vernon T. Launch of a Skin Care Regime to reduce the incidence of Moisture Associated Skin Damage. Doncaster and Bassetlaw NHS Foundation Trust. Presented at TVS, UK, 2016. **3.** Maxwell J, Sinclair D. Treatment of moisture related lesions in children. Great Ormond St Hospital for Children NHS Foundation Trust, London UK. Poster presented at EWMA 2012, Vienna, Austria. **4.** Meuleneire, F. A new solution in the treatment of moisture lesions. AZ St Elisabeth Zottegem, Belgium. Presented at EPUAP 2010. **5.** Ling L. Proshield skin care protective system: A sequence of evaluations. Gloucestershire NHS, UK. Presented at Wounds UK, 2011.

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PROSHIELD◊ Foam & Spray Incontinence Cleanser

Effective prevention and management of moisture lesions and IAD without rinsing or the use of a moisturiser, when used with PROSHIELD PLUS skin protectant.[1-3]

26%

Contributed to prevention of pressure ulcers and IAD[3]

pH balanced[4]

Formulated to help eliminate odour[5]

1. Ling L. PROSHIELD skin care protective system: A sequence of evaluations. Gloucestershire NHS, UK. Presented at Wounds UK, 2011. **2.** Flynn D, Williams S. Barrier creams for skin breakdown, *Nursing & Residential Care*. 2011; 13 (11): 553-558. **3.** Wall L, Vernon T. Launch of a Skin Care Regime to reduce the incidence of Moisture Associated Skin Damage. Doncaster and Bassetlaw NHS Foundation Trust. Presented at TVS, UK, 2016. **4**. Smith+Nephew 2019. Review of certificate of analysis for PROSHIELD Foam & Spray Incontinence Cleanser. RD/19/024. **5.** Technical file PROSHIELD Foam & Spray incontinence cleanser (product formulation/ specifications).

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PROSHIELD◊ PLUS
Skin Protectant

Smooth, viscous and fragrance free moisture barrier.[1,2]

Helps protect skin against IAD and moisture lesions[3-6]

Safe and effective for the management of moisture related skin damage[3,5,6]

Moisturises and conditions the skin[7,8]

3 of 3

1. Smith+Nephew 2019. Review of Certificate of Analysis for PROSHIELD Plus Skin Protectant RD.19.016. 2. Smith & Nephew 2019. Verification report for the viscosity of PROSHIELD PLUS Skin Protectant. U/064/R3. **3.** Ling L. PROSHIELD skin care protective system: A sequence of evaluations. Gloucestershire NHS, UK. Presented at Wounds UK, 2011. **4.** Flynn D, Williams S. Barrier creams for skin breakdown, *Nursing & Residential Care*. 2011; 13 (11): 553-558. **5.** Maxwell J, Sinclair D. Treatment of moisture related lesions in children. Great Ormond St Hospital for Children NHS Foundation Trust, London UK. Poster presented at EWMA 2012, Vienna, Austria. **6.** Meuleneire F. A new solution in the treatment of moisture lesions. AZ St Elisabeth Zottegem, Belgium. Presented at EPUAP 2010. **7.** Hoggarth A, Waring M, Alexander J, Greenwood A, Callaghan T. A controlled three-part trial to investigate the barrier function and skin hydration properties of six skin protectants. *Ostomy wound man* 2005; 51(12): 30-42. **8.** Howers L, Boyett F. Evaluation of Proshield Plus in nursing homes for inclusion onto formulary in a healthcare trust. NHS Surrey. Presented at Wounds UK 2012.

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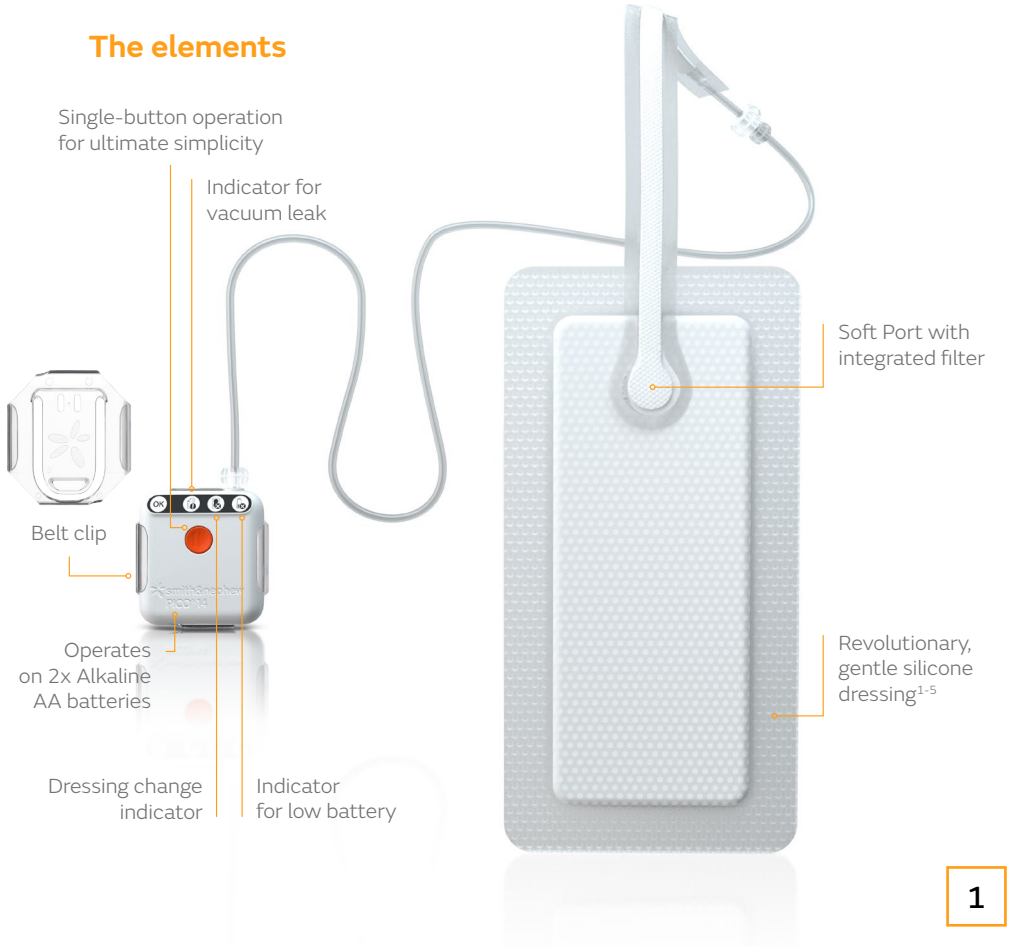
PICO◊ 14 and AIRLOCK◊ Technology dressing

The elements



AIRLOCK Technology for effective outcomes

Only **PICO** sNPWT has a proprietary **AIRLOCK** Technology layer

1. **Silicone adhesive layer** minimises pain on removal[1-5]
2. **Pioneering AIRLOCK Technology** transmits pressure evenly across the whole wound bed and surrounding zone of injury*[6,10]
3. **Super absorbent core** locking exudate away from wound*[6,7]
4. **Top film layer** has a high moisture vapour transmission rate and protects the wounds from external contamination*[8,9]
5. **PICO** Soft Port with integrated filter[11]

On average,
80%
of the exudate is lost by evaporation[6*]

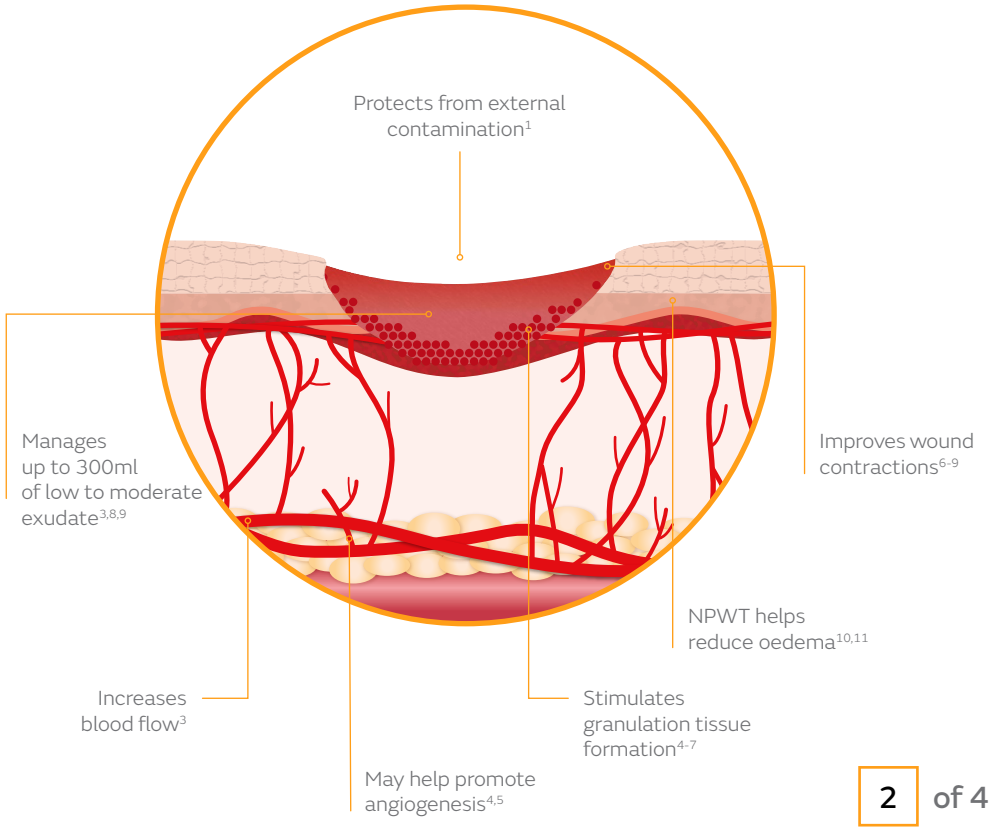
Approximately,
20%
fluid still remains in the dressing[6*]

In-vitro testing.

1. Hudson DA, Adams KG, Van Huyssteen A, Martin R, Huddleston EM. Simplified negative pressure wound therapy: clinical evaluation of an ultraportable, no-canister system. *Int Wound J.* 2015;12(2):195–201. **2.** Payne C, Edwards D. Application of the single Use Negative Pressure Wound Therapy device (PICO) on a heterogeneous group of surgical and traumatic wounds. *ePlasty.* 2014:152–166. **3.** Smith & Nephew May 2015. A prospective, open, non-comparative, multi-centre study to evaluate the functionality and dressing performance of a new negative pressure enhanced dressing (NPED) in acute wounds (CT09/02). Internal report. ST865 CT09/02. **4.** Sharp E. Single use NPWT for the treatment of complex orthopaedic surgical and trauma wounds. *Journal of Wound Care.* 2013;22(10):S5-S9. **5.** Stryja J, Staffa R, Říha D, Stryjová K, Nicielniková K. Cost-effectiveness of negative pressure wound therapy in outpatient setting. *Prolekare.* 2015. **6.** Malmsjo M, *et al.* Biological effects of a disposable, canisterless negative pressure wound therapy system. *ePlasty.* 2014;14:113-127. **7.** Smith+Nephew 2019. Summary report of *in vitro* wound model and negative pressure delivery (nominal -80mmHg) testing for PICO v2 (PICO 7 and PICO 14) System. Internal report. RD/18/134 V2. **8.** Smith & Nephew 2018. Summary of rountine QA testing on MVP of PICO Dressings. 2018. Internal report. DS/18/153/R. **9.** Lumb H. Data on file report.1102010. April 2011. **10.** Smith +Nephew 2019. PICO biomechanical study. Internal report. DS/19/211/R. **11.** Smith+Nephew 2018. PICO Soft Port Dressing Filter. Internal Report. RD.18.078.v1.

PICO◊ System

Mechanism of action (MoA)



- Protects from external contamination, acting as a bacterial barrier and locking bacteria away[1]
- Improves perfusion[2,3] via increase in blood flow[3] versus tNPWT
- Promotes micro-deformation, facilitating the generation of granulation tissue[4-7]
- Supports macro-deformation, facilitating wound contraction[4-7]
- Manages low to moderate exudate up to 300ml[3,8,9]
- NPWT helps reduce oedema[10,11]
- NPWT promotes lymphatic drainage[12]

1. Lumb H. Bacterial barrier testing (wet-wet) of PICO Dressing with a 7 day test duration against *S. marcescens*. February 2011 (*In-vitro*). Data on file report 1102010. **2.** Dowsett C, Huddleston E, Milne J. Reducing the burden of chronic wounds in the community with single-use NPWT Using disposable negative (2015). **3.** Malmsjö M, *et al.* Biological effects of a disposable, canisterless Negative Pressure Wound Therapy system. *ePlasty* 2014;14:e15. **4.** Dunn R, Hurd T, Chadwick P, *et al.* Factors associated with positive outcomes in 131 patients treated with gauze-based negative pressure wound therapy. *Int J Surg*. 2011;9(3):258–262. **5.** Young SR, Hampton S, Martin R. Non-invasive assessment of negative pressure wound therapy using high frequency diagnostic ultrasound: oedema reduction and new tissue accumulation. *Int Wound J*. 2013;10(4):383–388. **6.** Brownhill VR, Huddleston E, Bell A, *et al.* Pre-clinical assessment of single-use negative pressure wound therapy during *in vivo* porcine wound healing. *Adv Wound Care*. 2020 Jul 7. [Epub ahead of print]. **7.** Kirsner R, Dove C, Reyzelman A, Vayser D, Jaimes H. A Prospective, Randomised, controlled clinical trial on the efficacy of a single-use negative pressure wound therapy system, compared to traditional negative pressure wound therapy in the treatment of chronic ulcers of the lower extremities. *Wound Repair and Regeneration*. 2019;27(5):519–529. **8.** Roberts S. *In-vitro* wound model testing of PICO at a moderate exudate flow rate, March 2011. Data on file reference DS/11/037/R2. **9.** Roberts S. *In-vitro* wound model testing of PICO at a low exudate flow rate, April 2011. Data on file reference DS/11/057/R2. **10.** Kamolz LP, Andel H, Haslik W, *et al.* Use of subatmospheric pressure therapy to prevent burn wound progression in human: first experiences. *Burns*. 2004;30(3):253–258. **11.** Birke-Sorensen H, Malmsjo M, Rome P, *et al.* Evidence-based recommendations for negative pressure wound therapy: treatment variables (pressure levels, wound filler and contact layer)- steps towards an international consensus. *J Plast Reconstr Aesthet Surg*. 2011;64 Suppl:S1–16. **12.** Kilpadi DV, Cunningham MR. Evaluation of closed incision management with negative pressure wound therapy (CIM): hematoma/seroma and involvement of the lymphatic system. *Wound Repair Regen*. 2011;19(5):588-596.

presented at EWMA 2012, Vienna, Austria. **3.** Meuleneire F. A new solution in the treatment of moisture lesions. AZ St Elisabeth Zottegem, Belgium. Presented at EPUAP 2010.

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PICO◊ System
Clinical evidence

Kick start or accelerate healing in stalled wounds

The use of PICO System on stalled chronic wounds of diverse aetiology has been shown to:

- Reduce wound size by an average of 21% (one-fifth) each week[2]*
- Heal chronic wounds on average 10 weeks earlier than predicted with standard wound care dressings[2]*
- Heal chronic wounds six times faster than predicted with standard dressings[1,2]*†

On a 12-week treatment period for Venous Leg Ulcer and Diabetic Foot Ulcer wounds over four weeks old, PICO has been shown to:

- Significantly reduce wound area and depth compared to tNPWT[3] (Figures 1 and 2)‡
- Have an average wear time of 6.5 days for PICO dressings vs. 3.1 days for tNPWT[3]
- Be more than twice as effective at achieving wound closure than traditional Negative Pressure Wound Therapy (tNPWT) (45% vs. 22.2%)[3]

Figure 1. Wound area

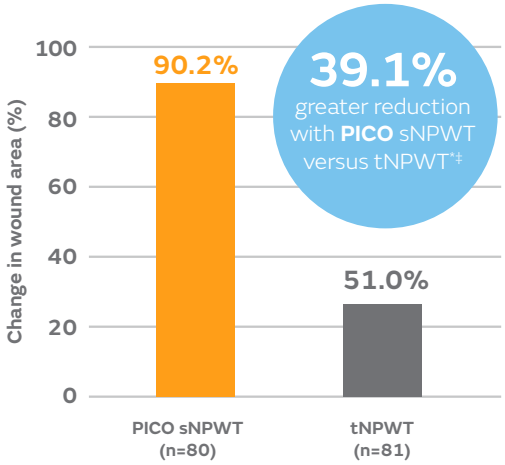


Figure 2. Wound depth

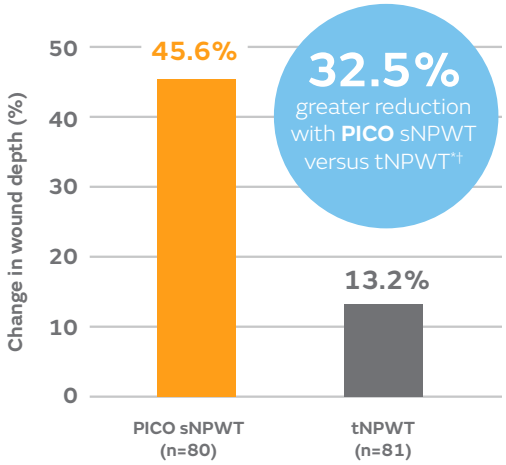
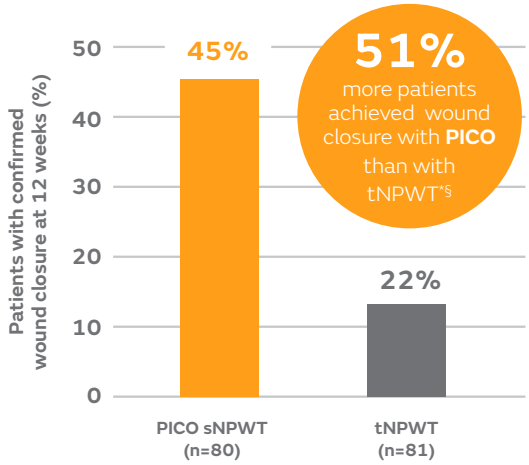


Figure 3. Wound closure



*Based on 5 out of 9 wounds responding; wound mean duration prior to study 44 week, study size n=9. †A prospective cohort study of 52 wounds, PICO healed wounds n=14. ‡These statistics come from two patient populations, which include outliers in the dataset.

1. Dowsett C, Hampton J, Myers D, Styche T. Use of PICO to improve clinical and economic outcomes in hard-to-heal wounds. *Wounds International*. 2017;8, p53–58. **2.** Hampton J. Providing cost-effective treatment of hard-to-heal wounds in the community through use of NPWT. *Br J Community Nurs*, 2015. Suppl Community Wound Care:S1, S16–20. (13). **3.** Kirsner R, Dove C, Reyzelman A, Vayser D, Jaimes H. A prospective, randomised, controlled clinical trial on the efficacy of a single-use negative pressure wound therapy system, compared to traditional negative pressure wound therapy in the treatment of chronic ulcers of the lower extremities. *Wound Repair and Regeneration*. 2019;27(5):519–529.

PICO◊ System
Clinical evidence

Healing rates following use of PICO System by wound duration[1]

Intervention with Negative Pressure Wound Therapy (NPWT) can be a great option for wound closure in indicated types of wounds. However, the time of intervention is critical, as the longer the wait, the lower the healing rates.[1]

Early intervention. 94% success rate in healing with PICO◊

Healing rates were nearly **x3** better among wounds treated <3 months-old, compared with treating those >1 year-old[1*]

*n=52; 0-3 vs 12+ months starting wound duration

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RENASYS◊ TOUCH Negative Pressure
Wound Therapy System

✓	Intuitive, user-friendly touchscreen interface for quick, easy-to-learn operation[1,2]
✓	Clinically effective for a range of chronic and acute wounds across a variety of care settings[3]
✓	Adjustable compression rate and variable intermittent mode allow for tailoring the therapy to an individual patient's needs and comfort[2]
✓	The leak gauge is designed to aid clinicians in locating and resolving air leaks[2]
✓	Easy-to-use onscreen quick reference guide supports device operation[2,4]
✓	Detailed pump activity log enables monitoring of patient concordance
✓	Up to 14 hours of battery life on a single charge[5]

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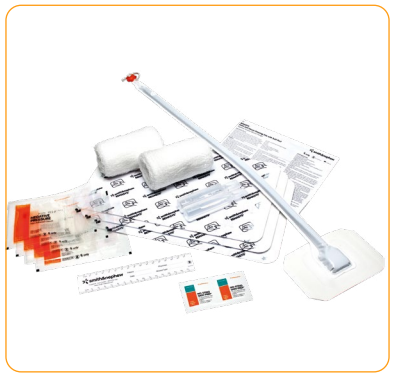

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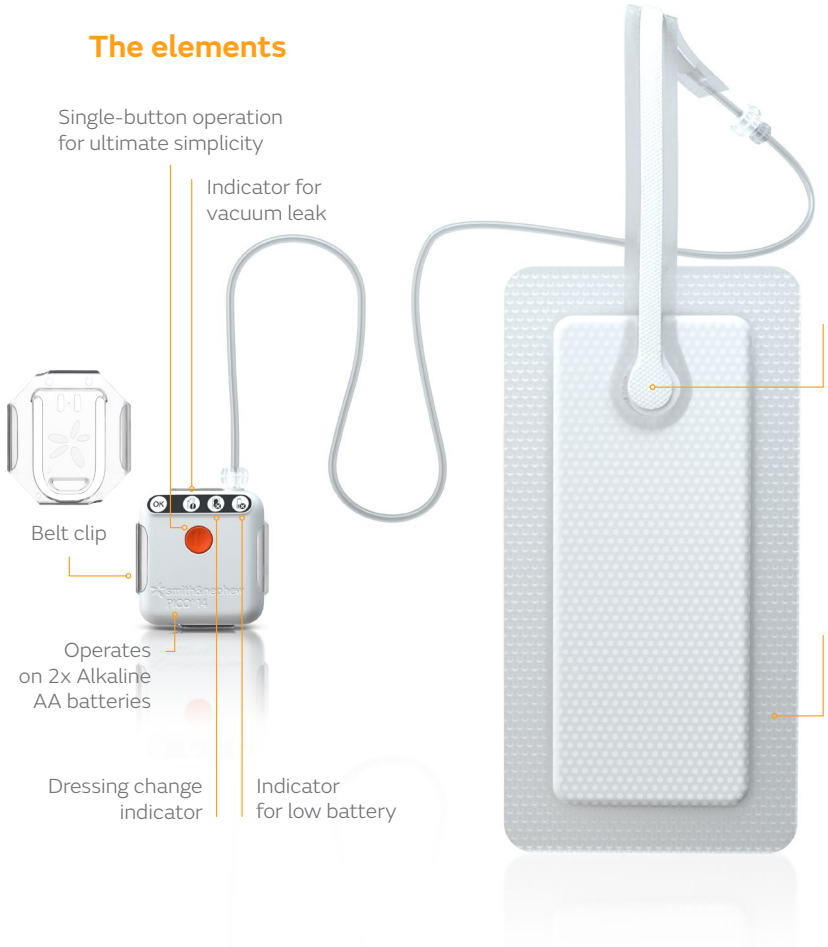
*n=96. †84.2% of 38 clinicians rated easier to apply. ‡n=38

1. Hurd T, Chadwick P, Cote J, Cockwill J, Mole T, Smith J. Impact of gauze based NPWT on the patient and nursing experience in the treatment of challenging wounds. 2010. *Int Wound J*. In Press. **2.** Bondojki, Samer DPM, *et al.* Clinical efficacy of an alternative foam-based Negative Pressure Wound Therapy system. Poster presented at The Symposium on Advanced Wound Care 2010. **3.** Carnali M, Ronchi R, Finocchi L, Spuri Capesciotti S, Paggi B. Retrospective study on the use of negative pressure wound therapy in the treatment of pilonidal cysts (sinus pilonidalis) operated on using an open technique or complicated by dehiscence of the surgery site through sepsis. *Acta Vulnologica*. Vol 14 2016:24–39. **4.** Smith & Nephew 2012. A prospective, open, non-comparative, multi-centre study to evaluate the functionality and device performance of a new Negative Pressure Wound Therapy (NPWT) suction port (RENASYS◊ Soft Port) in the management of acute, sub-acute and chronic wounds CSR/CT/US/11/01. **5.** Hudson D, Adams K, Cockwill J, Smith J. Evaluation of a new Negative Pressure Wound Therapy (NPWT) suction port (RENASYS Soft Port). Paper presented at: EWMA; 2013.

Smith+Nephew does not provide medical advice. The information presented is not, and is not intended to serve as, medical advice. For detailed device information, including indications for use, contraindications, precautions and warnings, please consult the product's Instructions for Use (IFU) prior to use. It is the responsibility of healthcare professionals to determine and utilise the appropriate products and techniques according to their own clinical judgment for each of their patients.

PICO◊ 14 and AIRLOCK◊ Technology dressing

The elements



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PICO◊ System

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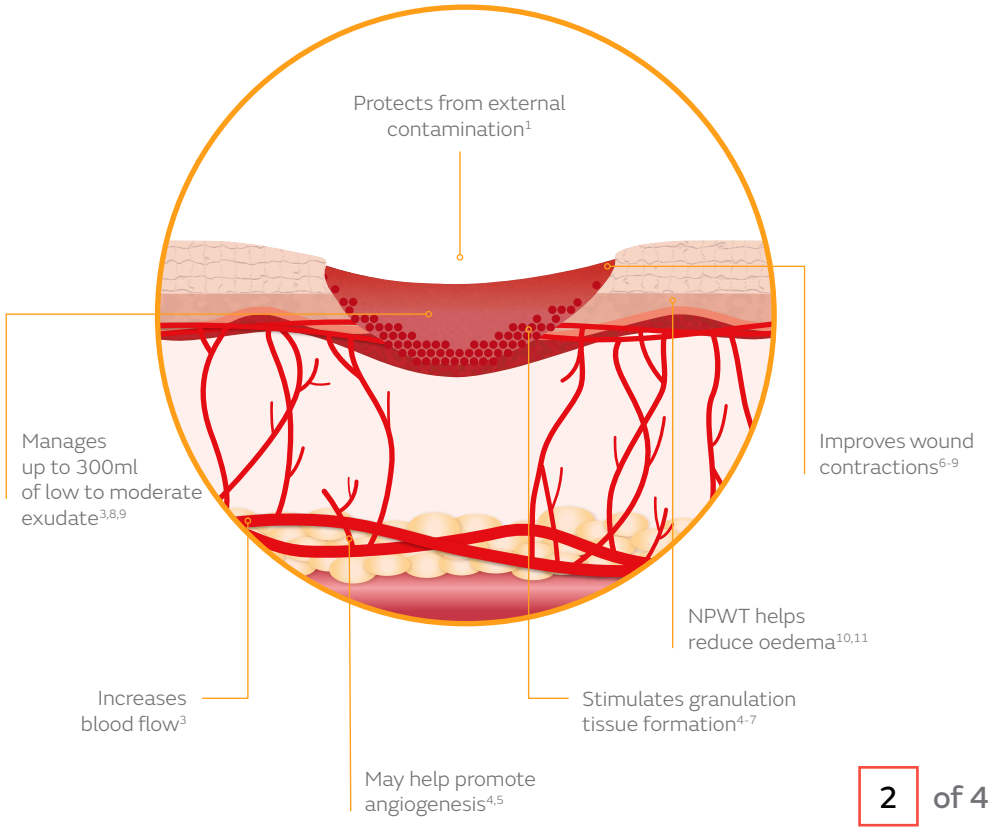

- Protects from external contamination, acting as a bacterial barrier and locking bacteria away[1]
- Improves perfusion[2,3] via increase in blood flow[3] versus tNPWT
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PICO◊ System
Clinical evidence

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The use of PICO System on stalled chronic wounds of diverse aetiology has been shown to:

- Reduce wound size by an average of 21% (one-fifth) each week[2]*
- Heal chronic wounds on average 10 weeks earlier than predicted with standard wound care dressings[2]*
- Heal chronic wounds six times faster than predicted with standard dressings[1,2]*†

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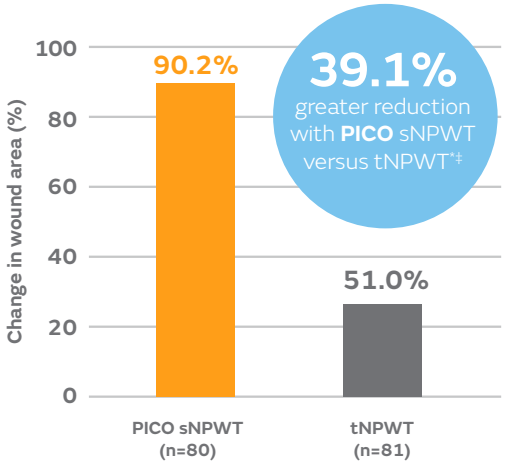

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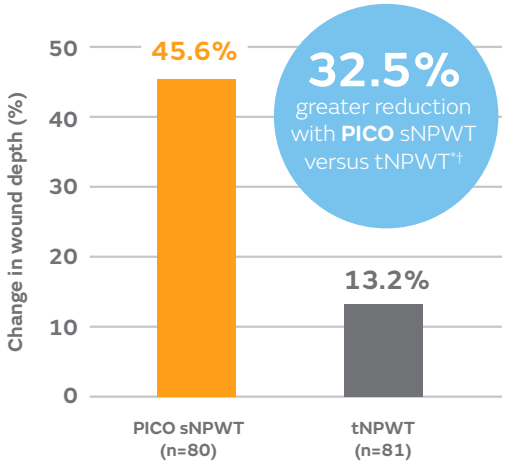

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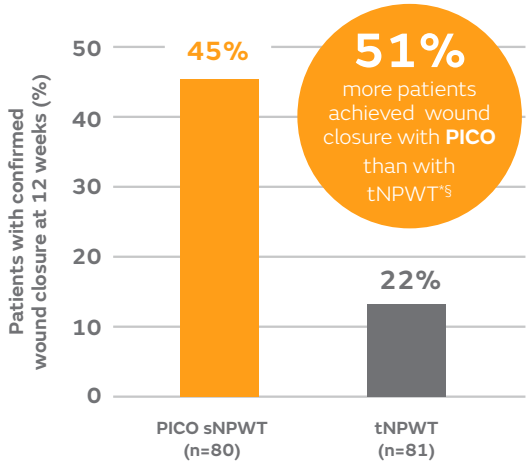

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PICO◊ 14 and AIRLOCK◊ **Technology dressing**

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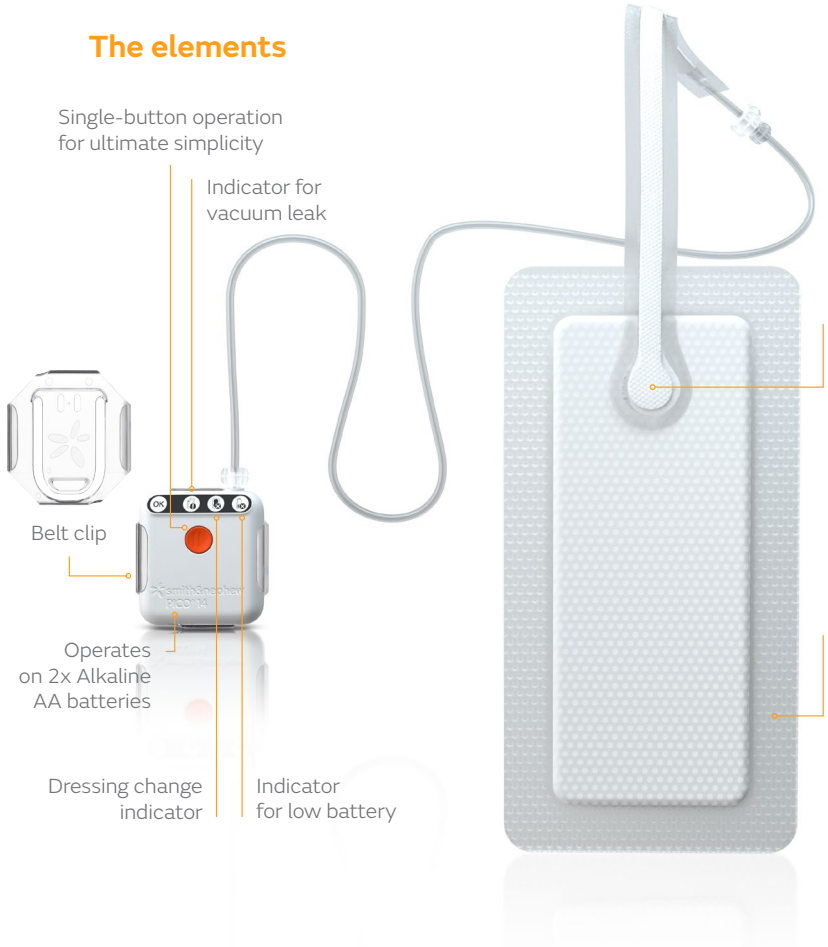

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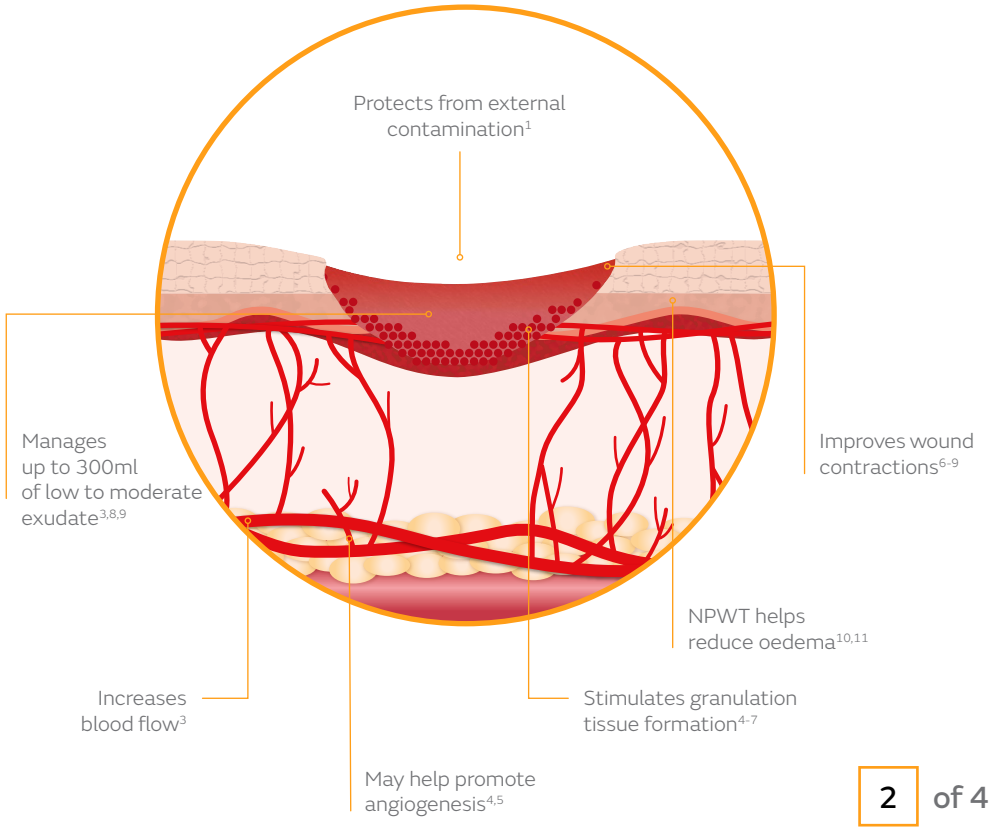

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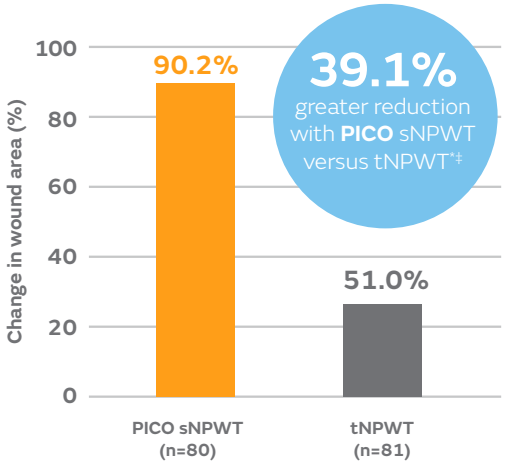

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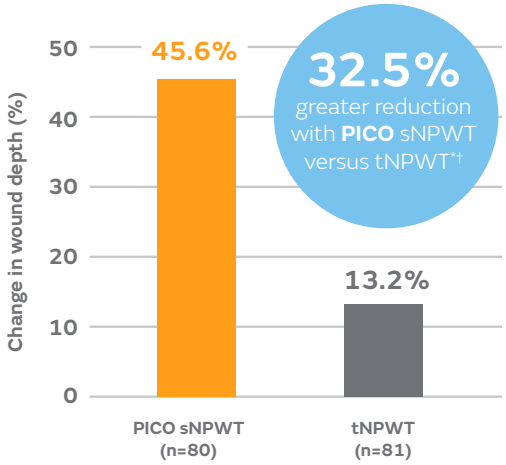

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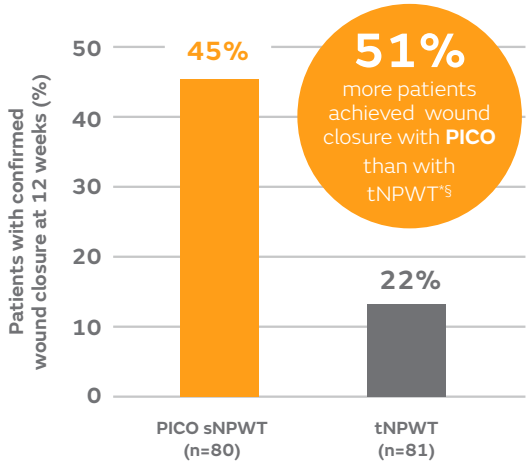

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