



Exudate pathway

Underlying factors



Systemic CCF, renal

- CCF, renal and hepatic failure
- Infection/inflammation
- Medication (NSAID, steroids)
 Obesity and malnutrition

Wound healing stage

- Inflammatory phase
 Static or delayed healing
 Autolytic debridement

Practical

- Wound position
 Concordance
- Inappropriate dressing choice

Local

- Local infection/inflammation
- Trauma Foreign body
- Oedema
- Sinus and fistula

Sensitivity

Exudate

colour

Red pink

- Post operative
- Traumatic dressing removal Possible infection
 - Clear straw colour Considered normal
 - Lymphatic/urinary fistula
- A response to inflammation
 Possible infection
 - Cloudy milky creamy
 - Green yellow

 Bacterial infection
 - Pseudomonas aeruginosa
 - Yellow brown

Viscosity

Thin and watery

Low protein content

- Urinary or joint fistula

Normal

Healthy exudate is thin watery, pale yellow or light red and does not adhere to the wound bed

Thick and sticky High protein content

- Liquefaction of necrotic tissue Presence of infection

of exudate

- Venous or cardiac disease
- Malnutrition
- Necrotic material
 - Infection or inflammatory
- Enteric fistula
- Lymphoedema can also cause an increase in protein rich fluid

Odour

Assess exudate odour

- Remove necrotic tissue if indicated
- Reduce bioburden and manage underlying infection
- Review frequency of dressing change

levels Exudate

Dry

- This is not an ideal wound healing environment
- No visible moisture
- Consider potential dressing adherence
- Surrounding skin may be scaly, atrophic and hyperkeratotic
- Consider moisturising skin

Wet

Moist

- Dressing may be extensively marked
- Potential fragmented areas of maceration

Dressing may be lightly marked

An ideal wound healing environment

Wound bed could appear glossy

Surrounding skin may be intact and hydrated

- Saturated
- Free fluid is visible on the wound
- Primary dressing is wet and strikethrough may occur
- Exudate may have begun to escape the dressing
- Risk of macerated and denuded skin



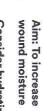
Leaking

- Primary and secondary dressings are saturated
- Fxudate is escaping from the dressing onto clothes/bedding

- High risk of macerated and denuded skin

dressings Rationale for

Dry



Consider hydrating the eschar

- Hydrogel
- Dry may be optimum for ischaemic wounds (consider vascular referral)

For low exudate

- Primary dressing: Hydrogel
- Secondary dressing: Foam adhesive Silicone foam Absorbent acrylic Film plus pad Hydrocolloid thin Hydrocolloid



Aim: To maintain wound moisture

Review dressing change frequency

- Secondary dressing:
 Adhesive foam
 Non adhesive foam
 Silicone foam Alginate Hydrogel
- Hydrocolloid Absorbent acrylic



Consider dressing frequency and select dressing for its fluid handling properties

Primary dressing:

Secondary dressing:

Alginate Hydrofibre

Super absorber

Saturated

Aim: To decrease wound moisture and protect peri wound area

- Primary dressing: Alginate Hydrofibre
- Peri wound film barrier

Aim: To decrease wound moisture and protect peri wound area



- Consider dressing frequency and select dressing for its fluid handling properties Primary dressing: Alginate
- Secondary dressing:
 Super absorber
 Adhesive foam
 Non adhesive foam
 Peri wound film barrier



Aim: To decrease wound moisture and protect peri wound area to prevent leakage on to clothing and bedding

Consider frequency of dressing change and select thicker more absorbent products

Topical negative pressure Superabsorbers Peri wound film barrier

Consider the possibility of infection and use appropriate antimicrobial/antibiotic if indicated