

Short Commentary

Clinical Evaluation of the Efficacy of Fitostimoline Hydrogel used for the Autolytic Debridement of Venous Ulcers

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Venous ulcers are the most common type of chronic ulcers, affecting frequently the lower limbs. Chronic venous ulcers significantly impact quality of life because of pain, risk of infections, need of medications and possibility of malignant transformation [1]. Accurate wound assessment is essential to guarantee appropriate goal setting. Debridement and bacterial load control are two initial steps of wound care [2]. There are many procedures for wounds cleaning and to reduce bacterial bioburden. It is important the appropriate treatment choice for any single case. Firstly, venous ulcers often present fibrin, one of the major factor that prevents healing process, and for this reason, a debridement of fibrinous tissue is necessary [3]. There are different type of debridement (enzymatic, autolytic, surgical etc.) and the common choice of not aggressive debridement depends on the impossibility to obtain an adequate anesthesia at home or in first level/private offices. Autolytic debridement is a selective and not aggressive method which causes removal of necrotic tissue due to the physiological moist wound environment, which exerts its own debriding capacity [4]. It is a painless and safe technique with effective action and with low costs because dressing are usually changed every two days.

Fitostimoline Hydrogel is a medical device consisting of Polyhexanide and Rigenase: Polyhexanide is an antiseptic that reduces the risk of bacterial contamination and it is considered the first choice in critically colonized or at risk of infection wounds [5]. Rigenase is a wheat extract with antioxidant and moisturizing properties [6]. The presence of purified water and polyethylene glycol contributes to rehydrate necrotic tissue, fibrin coating and liquefy dry eschar and slough [6]. In this study we used Fitostimoline Hydrogel in 26

patients (18 females and 8 males, aged between 52 and 92 years) affected by chronic venous ulcers of lower limbs, variable in size (9,6-26,5 cm²). The wounds were covered with slough in 60 % of cases and with dry eschar in the other 40 % of ulcers. A swab for bacterial bioburden control was performed in all the patients before treatment. Bacterial flora with colonization (high colonies >100.000 UFC/plate) was present in 17 wounds and was composed by Gram positive bacteria. The other ulcers presented a bacterial contamination. The ulcers were treated with one application of Fitostimoline Hydrogel every other day for 30 days. At the follow-up visit the fibrin and the necrotic eschar were reduced of more than 50% in all treated ulcers. Moreover, the residual necrotic material was easily removable with a curette. A control swab was performed without observing bacterial colonization in all treated ulcers.

In conclusion, based on our experience, Fitostimoline Hydrogel is a good therapeutic option for debridement and bacterial colonization control in chronic venous ulcers. Other studies are necessary to confirm our data.

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