

Silflex

Silflex with Silfix® (soft silicone wound contact dressing)



A wound contact layer made from polyester mesh and coated with Silfix® soft silicone. Silflex is designed to gently adhere to the skin surrounding a wound and not to the wound bed. This is an atraumatic dressing which means it is designed to minimise the pain and trauma associated with dressing change. The dressing allows the passage of exudate.

- Non-adherent to the moist wound
- Atraumatic soft silicone, reduced pain on dressing change
- Allows passage of exudate
- Hydrophobic Silfix® soft silicone coating
- Soft and conformable

Indications

- Skin tears
- Skin abrasions
- Surgical wounds
- Second degree burns
- Lacerations
- Leg and pressure ulcers

Size	No. in Box	Product Code
5 x 7.5 cm	10	CR3922
8 x 10 cm	10	CR3923
12 x 15 cm	10	CR3924
20 x 30 cm	10	CR3925

Manufactured by:

Case studies and published evidence

The use of Silflex in burn wound management

Edwards, Jacky: *Wound Care*, September 2009, University Hospital of South Manchester, UK; NHS Foundation Trust, Manchester.

Mr C was a 28 year old man who worked in a factory. He went to get hold of a Blowtorch, which exploded and splattered him with molten plastic. He suffered approximately 0.5% total body surface area burns to both hands. These were deep dermal/full thickness and as they were all the digits, function could have been compromised (Figure 1). To promote function and reduce pain it was decided to apply Silflex, with Flamazine to the burned areas (Figure 2) and the dressing was left in situ for 48 hours, until it was reviewed (Figure 3). At this review Mr C's pain was not an issue and he had a full range of movement. Full healing was achieved at 10 days post injury and at his 3-week review Mr C had an excellent result with no evidence of hypertrophic scarring, a common consequence of this depth of injury (Munro, 1995), and a full range of movement. Figures 4-5 show progressive healing.

Conclusion:

Finding the ideal dressing in burn care is very difficult when you have to take into account, pain, exudate and wound size. Silflex has been found to be very useful in managing burn wounds, comes in large sizes and can be used at all stages of wound healing, either in conjunction with or without topical antimicrobials. Given the learned nature of pain, dressings which don't hurt on removal present obvious benefits in this patient group. Anticipation of pain is as much a problem as actual pain, and if by using 'atraumatic' silicone-based products, this prevents this anticipation, it is likely that the overall pain experience of the patient will be greatly reduced.

Note: Munro KJG (1995) *Hypertrophic and Keloid Scars*, *J Wound Care* 4 (3): 143-8



Figure 1: Initial burn



Figure 2: Silflex dressing in-situ



Figure 3: Wound 48 hours after injury



Figure 4: Wound 10 days post injury



Figure 5: Wound reviewed 3 weeks post healing

Silflex® soft silicone wound contact dressing

Timmons, John; Gray, David; Russell, Fiona. *Wounds UK*, 2009, Vol 5, No. 2

A 65- year old man presented with a surgical excision to his left neck-cheek area following successful bone graft of fibula to his mandible. In preparation for a flap, the wound required debridement and development of granulation tissue

Figure 6 shows that the wound cavity has been debrided using surgical debridement and larval therapy to reveal bone, tendon and granulation tissue. At the upper part of the wound there exists sinus into the oral cavity and an exposed bone graft. The decision was taken to start negative pressure wound therapy (NPWT) to aid the development of granulation tissue. However it was also recognised that the exposed bone needed to be protected and so a Silflex soft silicone dressing was applied (Figure 7). To maintain the seal the sinus between the oral cavity was closed using Stomahesive paste (ConvaTec) (Figure 7).

The wound had previously been surgically debrided and had become infected and further necrotic tissue had developed. Larval therapy and surgical debridement were used to clear the area and and systemic antibiotics were used.

Negative pressure wound therapy was delivered with the V.A.C® Freedom® system (KCI Medical) using black foam and the dressing was changed every 48 hours. At each dressing change Silflex was used to cover the exposed bone graft (Figures 7 & 8).

Initial review:

At first review the wound dimensions measured 5x4x1cm with evidence of granulation growth in the wound bed (Figure 7). There was no evidence of wound infection and the bone graft remained undamaged (Figure 9).

Second review:

At the second review one week later, the wound bed was seen to be granulating well with some minor bleeding associated with form dressing removal which resolved in minutes. The Silflex® dressing had offered protection to the bone graft and the Stomahesive paste while the V.A.C Freedom system was in situ. At this review the wound dimensions had remained static, with the exception of the wound depth which has reduced to 0cm.

Conclusion:

Following the treatment regime combining Stomahesive, Silflex® silicone wound contact dressing and the V.A.C Freedom system, the patient underwent a successful pectoral flap to cover the defect.



Figure 6: The wound post-debridement using a mixture of larval therapy and sharp debridement



Figure 7: Stomahesive paste and Silflex silicone dressing in place before fitting the V.A.C. dressing (black foam).



Figure 8: Black foam placed over the Silflex soft silicone dressing.



Figure 9: The final assessment with granulation forming successfully across the wound bed and no damage to the bone graft. Dressing removal was atraumatic