HIDRADENITIS SUPPURATIVA

Definition – Hidradenitis suppurativa is a chronic follicular occlusive disease, characterized by recurrent painful, deep-seated nodules and abscesses located primarily in the axillae, groins, perianal, perineal and inframammary regions. The Second International HS Research Symposium (San Francisco March 2009) adopted the following consensus definition. “HS is a chronic, inflammatory, recurrent, debilitating, skin follicular disease that usually presents after puberty with painful deep seated, inflamed lesions in the apocrine gland-bearing areas of the body, most commonly the axilla, inguinal and anogenital region”. HS is frequently misdiagnosed as “boils”. This results in delayed diagnosis, fragmented care, and progression to a chronic, disabling condition that has a profoundly negative impact on quality of life.

The prevalence of hidradenitis suppurativa (HS) is described as anywhere from 1 in one hundred to 1 in six hundred. Women are more commonly affected than men. Some studies have described a predilection in patients of Afro-Carib descent, but this has not been confirmed in all. 25% of patients present between the ages of 15 and 20 and 53% are aged 21 to 30. Female to male ratios range from 2:1 to 5:1. Prepubertal cases are rare, but occasional onset in neonates and infants has been described. It is felt to arise secondary to some defect in the terminal follicular epithelium. The initial process is cornification of the follicular infundibulum followed by follicular occlusion. Folliculitis and destruction of the skin appendages and subcutaneous tissue occur. As the disease progresses, abscess and sinus tract formation occur. Apocrine glands become involved in the context of intense peri-follicular inflammation. Most recent papers concur that bacterial involvement is secondary and not causative to the disease process. The exact etiology of hidradenitis is unknown.

Diagnosis-Relies on the following diagnostic criteria:

1. Typical lesions: either deep-seated painful nodules (blind boils) in early primary lesions or abscesses, draining sinuses, bridged scars and “tombstone” open comedones in secondary lesions.
2. Typical topography: axillae, groin, genitals, perineal and perianal region, buttocks, infra- and inter-mammary folds.
3. Chronicity and recurrences.

These three criteria must be met to establish the diagnosis.

Multiple skin abscesses occur, with draining subcutaneous sinus tracts. Scarring and deformity are present in many individuals. Although biopsy is not absolutely required for diagnosis of HS, if you send tissue to pathology and tell them that the clinical picture is consistent with HS, they will likely look for the characteristic findings of follicular hyperkeratosis, active folliculitis or abscess, sinus tract formation, fibrosis, granuloma formation, apocrine and eccrine stasis and inflammation, fibrosis, fat necrosis, inflammation of the subcutis.

Differential diagnosis – Multiple conditions are to be considered in the differential diagnosis of hidradenitis suppurativa.

Infections
- Bacterial - Carbuncles, furuncles, abscesses, ischiorectal/perirectal abscess, Bartholin’s duct abscess
- Mycobacteria – TB
- STI– granuloma inguinale, lymphogranuloma venereum, syphilis
- Deep fungi – blastomyces, nocardia

Tumors Cysts – epidermoid, Bartholin’s, pilonidal
Miscellaneous Crohn’s, anal or vulvovaginal fistulae

**Clinical features** – Early/primary lesions are a single, painful, deep-seated nodule 0.5-2cm, round, no “pointing” that may resolve, persist as a “silent” nodule that can recur, or abscess and drain and recur even if surgically drained. With time these can go on to chronic, recurrent lesions at same site, coalescing with fibrosis and sinus formation. Lesions persist for months with pain and drainage with foul odor. These can result in tertiary lesions with hypertrophic fibrous scarring with “bridged scars” forming rope-like bands with active, painful, inflammatory nodules and sinus tracts forming thick plaques over an area. Thick scarred areas can result in decreased mobility and lymphedema.

Lesion course – most form an abscess, rupture and drain purulent material then may resolve and/or recur, form a chronic sinus that can drain with a seropurulent and/or bloody discharge, ulcerate, burrow and rupture into nearby lesions.

**TREATMENT PRINCIPLES**

**Therapy and prognosis** – Planning treatment follows severity grading. The first two stages respond to medical treatment whereas the third stage requires biologics and surgery. All patients will need thorough education and constant reassurance and support.

**Treatment**

- Define the frequency of the flares and the intensity of the pain when deciding upon treatment.
- A permanent cure is achieved only with wide, thorough, surgical excision
- Combine medical and surgical treatment

**Goals of treatment of hidradenitis:**

1. To reduce the extent and progression of the disease to bring it to a milder stage
2. To heal existing lesions and prevent new ones from forming
3. To allow regression of scars and sinuses in cases of extensive hidradenitis suppurativa

**Hurley’s criteria for Hidradenitis Suppurativa Staging**

Hurley’s criteria for Hidradenitis Suppurativa Staging – used to assess severity

Treatment principles – choose treatment to fit disease severity staging

**Stage I:** Abscess formation, single or multiple without sinus tracts and cicatrisation/scarring.

**Stage II:** Recurrent abscesses with sinus tracts and scarring. Single or multiple widely separated lesions

**Stage III:** Diffuse or almost diffuse involvement or multiple interconnected tracts and abscess

70% stay in Stage I
28% progress to Stage II
4% progress to Stage III
General Hidradenitis Suppurativa Treatment
Education, diet and support
Improve environment:

- Reduce friction in the area, heat, sweating and obesity
- Loose clothing, boxer-type underwear
- Tampon use if appropriate / avoid pads
- Use antiseptic washes
- Consider anti-androgen treatment
- Stop smoking

Antiseptic wash – triclosan cleanser
Anti-androgen if appropriate
Stop smoking

Treatment - Hurley’s Stage I
Abscess formation, single or multiple without sinus tracts and cicatrisation/scarring.

This is the most limited form of disease and it is amenable to medical therapy.
The majority of patients with Stage I have a few flares a year, however they can be well controlled.

Medical Treatment for Stage 1 hidradenitis suppurativa

Topical antibiotics
- Clindamycin 1% lotion bid

Intralesional
- Triamcinolone acetonide 10 mg/mL, 0.5 to 1 ml injected with a 30g needle into individual, painful, early papules / small nodules to suppress inflammation. Inject right into the center of the lesion

Systemic Antibiotics (for 7-10 days) - wide choice
- Tetracycline 250-500mg po qid or doxycycline 100 mg po bid or clindamycin 300 mg po bid, or amoxicillin / clavulanic acid 500mg-1gm po q 8h
- Caution in patients with diabetes- high dose steroids can interfere with their glucose control.

Adjunct preventive therapy
- Zinc gluconate 50 mg po bid

Anti-androgens
- Yasmin – consider extended regimen (daily x 84 – 126 days)
- Yasmin plus spironolactone

Consider:
Resorcinol 15% - apply to skin up to tid. Disp 3 mos supply with 3 refills. Bedford Pharmacy in New Hampshire. 603-472-3919 Have patient call first to discuss cost. They may desire 1 month supply with 11 refills.

Surgical Treatment – not usually needed for Hurley’s Stage I

General Care
- Avoid irritants
- Loose clothing
- Stop smoking
- Weight loss
**Maintenance**
Continue above as needed

**Treatment - Hurley’s Stage II**
Recurrent abscesses with sinus tract formation and scarring, either single or multiple widely separated lesions

The aim is to clear these patients or at least reduce them to stage I disease. If there are sinus tracts and scarring this will require combined medical and surgical therapy. For those with little scarring and much inflammation use antibiotics such as rifampin and/or clindamycin for 3 months and then decrease to maintenance on tetracyclines and/or high dose zinc and/or dapsone.

General care and intraleisonal treatment is the same as for stage I. Antibiotics for at least three months are usual, with a decreased dose for maintenance. Systemic antibiotics include tetracycline, as above or, for more extensive disease, clindamycin 300 mg twice a day often combined with rifampin 300 mg twice a day for three months. (See below for prescribing details) Dapsone 100 mg per day can be used. (See below for prescribing details) Long-term maintenance is with a tetracycline etc. (as below) is often recommended. The same adjunctive therapy with zinc gluconate and anti-androgens can be used as above.

**A. Medical Treatment for Stage II**
Topical antibiotics
- Clindamycin 1% lotion twice a day
Systemic Antibiotics
- Amoxicillin and clavulanic acid 3g loading then 1g po q8h for 5-7 days for acute painful lesions or
- Clindamycin 300 mg po bid with / without Rifampin 300 mg po bid or Dapsone 50 mg po and then 100 mg po with the appropriate blood work (See below for prescribing details).
- Maintenance – Tetracycline 250-500 mg qid, doxycycline or minocycline 100 mg bid

**Adjunct preventive therapy**
Zinc gluconate 50 mg po bid or 30 mg po tid
Anti-androgens
- Yasmin – consider extended regimen (daily x 84 – 126 days)
- Yasmin plus spironolactone
Intraleisonal triamcinolone as in Stage I

**B. Surgical Treatment** – If there are persistent chronic sinus tracts or cysts then obsessive surgical wide unroofing is necessary. Incision and drainage (I and D) should be avoided. Only do this for a tense abscess that is too painful to bear. Acute painful lesions sometimes develop into severely painful abscesses that need to be drained for pain relief only. This is not a curative procedure and needs concurrent antibiotics in full dose. Amoxicillin and clavulanic acid 3g in a single dose, then one gram po tid for 5-7 days is recommended. The lesion must be incised. Packing the wound for a few days may be needed to prevent premature superficial closure while the wound fills in from below

**C. and D. General Care and Maintenance** - as for Stage I
Treatment - Hurley’s Stage III
Diffuse or almost diffuse involvement or multiple interconnected tracts and abscess

This stage is a surgical disease and supportive concurrent medical treatment is both prophylactic and essential. This requires a staged medical – surgical team approach

A. Medical Treatment
Pre-Op - These patients will need the anti-inflammatory effects of medical treatment to prepare them for surgical treatment.
Corticosteroids 0.5 – 0.7 mg/kg/d methylprednisolone or prednisone (oral)
Cyclosporine 4 mg/kg/d po
Methotrexate 15 mg oral or subcutaneously weekly
TNF-α inhibitors
Remicade 5 mg/kg I.V Q6 weeks – use with the help of a knowledgeable health care provider
Clindamycin 300 mg po bid with Rifampin 300 mg po bid
Note – Medical treatment at this stage is only palliative and temporary.

B. Surgical Treatment
Wide surgical unroofing and debriding of all cysts and sinuses and fistulous tissue by a knowledgeable surgeon. Healing can be by secondary intent or it may be accelerated with mesh grafting. Primary closure is avoided in active disease. At times skin flaps are required.

Pre-operative Clinic: Reminders for Hidradenitis Patients

1. Consider Nutrition consult - screening tool per nutrition: albumin and prealbumin with preop labs
2. Encourage tobacco cessation; discuss impact on wound healing, need for avoidance of nicotine replacement products post-operatively.
3. Give instructions for extensive bowel prep (MiraLAX/Gatorade), use Golytely prep if h/o kidney or heart disease. The patient must be clear prior to OR.
4. Correct anemia prior to OR.
5. If not on OC’s, try to schedule surgery in luteal phase to avoid menses in post-operative time frame.
6. Counseling re: extent of excision, possibility of recurrence, prolonged hospitalization (at bed rest) and healing time.
7. Counseling re: NPO except for chips in hospital with TPN and rectal tube (Bard Dignicare).
8. Obtain GI consult to rule out Crohn disease or ulcerative colitis
    serologic markers for Crohn's pANCA,
    ASCA, OmpC and CBir1 Flagelin markers (IBD panel)
    If needed, consider upper GI evaluation as well as colonoscopy.
9. Psychological needs to be addressed prior to OR. Consider Pain Psychology consult or psychiatry consult if indicated. Let sexual counselor know about admission dates so they can visit her.
10. Discuss possible transfusion (need adequate HCT for adequate healing- HCT should be over 30 if flap done).
11. Mandatory arm and leg workouts should be agreed upon prior to surgery.
12. Let Pat Wojno know about scheduled surgery. She can assist in arranging bed for patient (Sport bed). The person in charge of the beds is Mary Serino, Clinical Care Coordinator Expert, UH PACU. Pager 30746.

12. Day before surgery:
- In Pre-admit orders, place an order for “Specialty bed” – this is ONLY a request for review for specialty bed. Enter ALL of the patient’s pertinent information into the order (who she is, how extensive her surgery will be, how long she will be on bedrest). Submit the order. Then PAGE 7156 - these are the people that help review the order. Reiterate the importance of the bed for the patient’s recovery. Ask that it is delivered to the OR the following day – emphasize importance that patient does not need to be moved from bed to bed (she can be placed on the specialty bed immediately out of the OR).

13. Arrange PICC line on POD 0 or 1 if TPN required (triple lumen). TPN not required for less than 7 day stay.
--Less than 7 days of parenteral nutrition therapy is unlikely to provide any clinical benefit and may increase infectious and metabolic complications.

14. Arrange for a Sport specialty bed. On case request under questions where it prints on schedule…specialty bed needed. State why in detail (long hospital stay at bedrest, sport bed is a low air loss bed that can be placed in Trendelenburg position for the rectal tube decompressions, etc. May need to page ostomy nurses day before surgery ideally in order to allow bed to be ordered and delivered to the OR.

15. Neurontin in preop holding (300-1200 mg).

16. Consent for 3 procedures, plus numerous additional wound vac changes
   1. Radical vulvectomy, excision of buttock and thighs and wound vac(s) placements
   2. Wound vac removals and replacements, Split thickness skin graft after wound cleaning and wound vac(s) placements
   3. Removal of wound vacs and staples
   4. Additional wound vac placements and removals

Will require 2 OR tables for extensive disease (rotate from prone to lithotomy). For prone, need gel pads, pillow and elbow protectors. Tilt bed when moving from prone to lithotomy. Also, finalize wound vac on OR table rather than on S bed.

Consents for procedures

A bowel preparation prior to surgery is important if the anal area is involved and a wound VAC over that area is anticipated. It is a good idea anyways if a major area of the vulva is involved. The patients should be evaluated for malnutrition prior to surgery.
OR 1
Intra-operative: Have Available for OR#1 (Radical Vulvectomy)

Bard Dignicare rectal tube  PUT IN RECTAL TUBE PRIOR TO PREP

Instructions for Use
1. Preparation of catheter and collection bag
   a. Attach the 60 ml syringe to the inflation port and draw all air from the retention cuff.
   b. After the cuff has been deflated, fill the syringe with 45 ml of water and set aside.
   c. Attach the collection bag to the catheter by inserting the ball valve connector of the catheter into the hub socket on the collection bag and turning clockwise until the connector snaps into place.

2. Insertion of Device
   a. Unfold the length of the catheter to lay flat on the bed towards the foot of the bed
   b. Attach the 60 ml syringe filled with 45 ml of water to the inflation port.

Insert the inflation cuff using a four-step process:
1. Squeeze the inflation cuff to ensure all air has been removed and hold the cuff flat in order to fold for insertion.

2. Holding the left point of the cuff between the thumb and index finger, fold the top right point of the cuff down and to the left in a 45 degree angle to create a conical shape with a leading edge for easy insertion.

3. Coat the cuff end with lubricating jelly

4. Gently insert the cuff end through the anal sphincter until the cuff is beyond the external orifice and well inside the rectal vault.

Inflate the cuff with 45 ml of water by slowly depressing the syringe plunger. As the cuff inflates, the pilot balloon also inflates. The inflation port needs to remain parallel to the catheter.

Remove syringe from inflation port and gently pull on the silicone catheter to check that the cuff is securely in the rectum.

Position tubing on the inner leg.

Insert bag plug

Bulb needs to be filled with 45 cc water whenever in bed except for when deflated as follows:
Deflate for 5 minutes q 12 hours in 15 degrees Trendelenburg. It can be used for 29 days. Periodically milk the catheter to facilitate flow. Change the collection bag before it becomes too full (between 600 and 800 ml). If the catheter becomes blocked with solid particles it can be rinsed with water. Flush both tubes q 6 hours with fluid (water) tube flushes should be alternated with bulb deflation so that there is tube manipulation q3 hours.

Supplies

For prone, need gel pads, pillow and elbow protectors

Stryker irrigator with X-Ray bag
Yellow fin stirrups

Set Coag at 40/40 Blend

Supplies for aerobic and anaerobic culture of wound bed

Ligasure Cautery Hand (one large one for abdomen and mons pubis and one small or medium one for vulva)

VAC foams (Silver (granu foam) for post-vulvectomy OR 1

VAC machine, canister and dressings OF NOTE: Wound VAC must be on anterior vulvar aspect near mons. Make sure nothing is covering the holes on the wound VAC tube insertion point.

Deflate wound VAC by attaching suction to wall suction for rapid deflation. Then clamp tube and connect to Wound Vac. Unclamp tube. Wound VAC should be set for OR 1 continuous at 125 to 150 (continuous). Consider 2 wound vacs if large area involved. One at superior aspect and one at mons level versus on buttock.

To prevent further leaks around the Foley and the rectal tube use a Hollister urostomy wafer cushion over the initial wound vac plastic covering, stock number 7806. They keep them with the urology supplies. Cut a slit to the center and use the smaller one for the Foley, and the larger, one around the rectal tube (need to trim this one).

For large buttock resections start on prone (For prone, need gel pads, pillow and elbow protectors.) Cover the edge of the first part of the area excised with mastisol (need at least 4 of them) on edge. Then cover the excised area with wound VAC foam and wound vac plastic sheeting, leaving a portion of the wound vac approaching the perineum unsealed. Cover this with sterile towels, and then roll to lithotomy position. This way, the buttock can be sealed easily.

WOUND VAC:

1) Make sure everything is dry, especially under the buttocks. Apply sticky plastic sheeting using ~1 inch strips around graft site in window pane fashion. This helps protect the skin and create a better seal.
2) Cut foam to fit Vulvectomy site. Silver-impregnated foam for OR 1 and first wound VAC change to improve antibacterial properties. Slits/holes are needed for the Foley and rectal tube.
3) Apply Mastisol (need at least 4) to the skin -- this can even go over the window pane plastic. It's especially important over the buttocks.
4 Apply Hollister wafer cushions around Foley and rectal tube after foam is covered with intial plastic sheeting for wound VAC. For the rectal tube, cut a slit in the Hollister wafer to open it, then enlarge the hole a bit. Apply it around the tube and overlap to create a better seal.
5) Use window paning technique around Hollister wafers to get better seal.
6) Have Coloplast Strip available to help seal wound VAC around Foley and rectal tube. The strip should also be placed in the gluteal cleft to allow for a better seal of the VAC sheeting into the buttocks region.

7) Put plastic sheeting/Tegaderms/etc. over foam to get good seals everywhere.
8) When ready to attach wound vac, cut a quarter-sized hole in plastic and apply the wound vac connector.
9) When starting suction, first deflate foam and remove as much air as possible using surgical suction (wall suction) canisters, and compress foam with hands to get as much air out as possible and get a better seal. Once the foam is essentially completely deflated, connect tubing to wound vac device.
10) Connect wound vac as above.

If any problems with wound VAC, can contact
Anthony Kann
(517)304-9814
Anthony.kann@kci1.com

Make sure the Foley is draining at the correct angle
Make sure the rectal tube is at the correct angle. Irrigate with 60 cc water through Catheter irrigation port to make sure draining correctly
Take back from OR on Sport specialty bed.

NEED PICC line placed after OR on floor (triple lumen). Optimal placement at cavoatrial junction. OK if in distal 1/3 of SVC to cavoatrial junction. Once radiologist pages the nurse that placed the PICC, they page the resident to place the order to use the PICC.

**OR 2 (Wound Debridement and Wound Vac Changes)**. Ok to take to OR on Sport specialty bed for transfer back to floor to minimize risk of disrupting wound vac seals.

Intra-operative
Have Available for OR #2 (Wound Debridement and Wound Vac Change)

**Set Coag at 40/40 Blend**

Yellow fin stirrups
Stryker irrigator with X-Ray bag
Vac machine(s), canister(s) and dressings.
Change rectal tube prior to prep

**Bard Dignicare Rectal Tube**

Fill bulb with 45 cc fluid water. Deflate the bulb with patient in 15 degrees Trendelenburg qd for 5 mins. every 6 hours. Periodically milk the catheter to facilitate flow. Change the collection bag before it becomes too full (between 600 and 800 ml). If the catheter becomes blocked with solid particles it can be rinsed with water. Flush both tubes q6 hours with saline or water. The tube flushes should be alternated with the bulb
deflations such that rectal tube manipulations occur q3 hours. The patient does not need to be put into Trendelenburg position for tube flushes.

If buttocks are involved, start in prone position (For prone, need gel pads, pillow and elbow protectors.) Consider tissue cultures. Debride buttock wound and replace wound vac, including sealing plastic sheeting around area. Make sure rectal tube is at proper angle to allow for drainage. Replace rectal tube at beginning of procedure prior to prep.

Once in lithotomy position, debride wound and replace remainder of wound vac.

**WOUND VAC:**

1) Make sure everything is dry, especially under the buttocks. Apply sticky plastic sheeting using ~1 inch strips around graft site in window pane fashion. This helps protect the skin and create a better seal.
2) Cut foam to fit Vulvectomy site. Silver-impregnated foam for OR 1 and first wound VAC change to improve antibacterial properties. Slits/holes are needed for the Foley and rectal tube.
3) Apply Mastisol (need at least 4) to the skin -- this can even go over the window pane plastic. It’s especially important over the buttocks.
4) Apply Hollister wafer cushions around Foley and rectal tube after foam is covered with initial plastic sheeting for wound VAC. For the rectal tube, cut a slit in the Hollister wafer to open it, then enlarge the hole a bit. Apply it around the tube and overlap to create a better seal.
5) Use window paning technique around Hollister wafers to get better seal.
6) Have Coloplast Strip available to help seal wound VAC around Foley and rectal tube. The strip should also be placed in the gluteal cleft to allow for a better seal of the VAC sheeting into the buttocks region.
7) Put plastic sheeting/Tegaderms/etc. over foam to get good seals everywhere.
8) When ready to attach wound vac, cut a quarter-sized hole in plastic and apply the wound vac connector.
9) When starting suction, first deflate foam and remove as much air as possible using surgical suction (wall suction) canisters, and compress foam with hands to get as much air out as possible and get a better seal. Once the foam is essentially completely deflated, connect tubing to wound vac device.
10) Connect wound vac as above.

If any problems with wound VAC, can contact

Anthony Kann  
(517)304-9814  
Anthony.kann@kci1.com

Make sure the Foley is draining at the correct angle  
Make sure the rectal tube is at the correct angle. Irrigate with 60 cc water through Catheter irrigation port to make sure draining correctly  
Take back from OR on Sport specialty bed.

OF NOTE: Wound VAC must be on anterior vulvar aspect near mons. Make sure nothing is covering the holes on the wound VAC tube insertion point. Set at continuous at 150 mm Hg if large area (less if small area).
Make sure everything is dry, especially under the buttocks. Apply sticky plastic sheeting using ~1 inch strips around graft site in window pane fashion. This helps protect the skin and create a better seal.

Deflate wound VAC by attaching suction to wall suction for rapid deflation. Then clamp tube and connect to Wound Vac. Unclamp tube. Wound VAC should be set for OR 1 continuous at 125 to 150 (continuous). Consider 2 wound vacs if large area involved. One at superior aspect and one at mons level versus on buttock.

Make openings quarter size. Make sure nothing is covering the holes on the wound VAC tube insertion point. Set at continuous at 125-150 mm Hg (if large area) (125 if small area).

The only foam to be used with the wound VAC on the skin grafts is black foam (NO silver foam!) Can cover flaps with wound vac too.

Consider having Flexinet in the OR for use in holding thigh wrap.

**OR 3 (Skin Grafts)** (Consider Flap with this surgery if needed. If a flap is done, the edges of the flaps need to be excised to healthy tissue.)

Stop Heparin 12 hours before OR.

Take to OR on specialty bed, then transfer to OR bed.

If flaps (especially muscle flaps with vessels reattached) performed, keep Hct above 30% to ensure wound healing.

Have Available for OR#3 (Split Thickness Skin Graft)

Do not use Duraprep on thighs

**Set Coag at 40/40 Blend**

Blue Allen stirrups (ask for CJ’s stirrups)
Stryker irrigator with X-Ray bag
VAC machine, canister and dressings
Deflate wound VAC by attaching suction to wall suction for rapid deflation. Then clamp tube and connect to Wound Vac. Unclamp tube. Wound VAC should be set for OR 1 continuous at 125 to 150 (continuous). Consider 2 wound vacs if large area involved. One at superior aspect and one at mons level versus on buttock.

Make openings quarter size. Make sure nothing is covering the holes on the wound VAC tube insertion point. Set at continuous at 125-150 mm Hg (if large area) (125 if small area).

The only foam to be used with the wound VAC on the skin grafts is black foam (NO silver foam)
Consider having Flexinet in the OR for use in holding graft flat and tight against bed.

For skin grafting procedure:

Have available large curette used by plastic surgery for debridement.
Dermatome setting: 12 to 17/1000 inch (15 ideal)
NEED TO CLEAN OUT Dermatome and relubricate it after 4 passes 3 inch guard.
Meshed 1.5/1.
Need extra carriers.
Have an assistant to gently lift up the skin graft if it piles up on the guard.
Change blade every 3 to 4 passes.
Consider if you will need to prep both thighs; wipe off thighs with water or saline prior to putting on mineral oil prior to doing skin graft.
When doing the skin graft use a 45 degree angle. Can use towel clips, or just push down on the skin.

Intra-operative
Start in prone position if both sides are being done. For prone, need gel pads, pillow and elbow protectors. Remove and replace rectal tube prior to prep.

Have Coloplast Strip available to help seal wound VAC around Foley and rectal tube. The strip should also be placed in the gluteal cleft to allow for a better seal of the VAC sheeting into the buttocks region.

**Bard Dignicare Rectal Tube**
Fill bulb with 45 cc fluid water. Deflate the bulb with patient in 15 degrees Trendelenburg qd for 5 mins. every 6 hours. Periodically milk the catheter to facilitate flow. Change the collection bag before it becomes too full (between 600 and 800 ml). If the catheter becomes blocked with solid particles it can be rinsed with water. Flush both tubes q6 hours with saline or water. The tube flushes should be alternated with the bulb deflations such that rectal tube manipulations occur q3 hours. The patient does not need to be put into Trendelenburg position for tube flushes.

Obtain grafts. After taking the graft, cover the thigh with epinephrine 1:1,000 - to make up, dilute 60 cc bottle of epi in 1000 cc saline. Soak Telfa in the dilute epi solution to place on donor sites. (If small area can use 1% lidocaine with 1:200,000 epinephrine on raytec)

1) On buttock, need to apply a narrow skin graft in buttock groove vertically a, then cut two additional skin pieces to go on either side of central piece that indents some. Make sure everything is dry, especially under the buttocks. Cover over with Adaptic (Curity Non Adhering Dressing 5 x 9). Ensure that there is overhang of the Adaptic (Curity Non Adhering Dressing 5 x 9) over the edge of the incision sites so that if things bunch, the skin is still protected.
2) Apply Mastisol (need 4) to the skin -- this can even go over the window pane plastic. It's especially important over the buttocks.
3) Cut black foam to fit buttock graft site. Slits/holes are needed for the Foley and rectal tube. The foam pieces can be stapled together to keep the shape and location as desired. Need to apply a narrow sponge in buttock vertically over Adaptic (Curity Non Adhering Dressing 5 x 9) covering skin graft, then cut two additional sponges and staple them to the buttock central sponge.
4) Apply Hollister wafer cushions around Foley and rectal tube after initial covering with plastic sheeting. For the rectal tube, cut a slit in the Hollister wafer to open it, then enlarge the hole a bit. Apply it around the tube and overlap to create a better seal.
5) Use window paning technique around Hollister wafers to get better seal.
6) Put plastic sheeting/Tegaderms/etc. over foam For buttock flaps cover the buttock with towels, then roll to lithotomy position. This way, the buttock can be sealed easily later on. To prevent further leaks around the Foley and the rectal tube use a Hollister urostomy wafer, stock number 7806. They keep them with the urology supplies. Cut a slit to the center and use the inner, smaller part for the Foley, and the larger, outer part around the rectal tube, after plastic sheeting has been applied.

7) When ready to attach wound vac, cut a **quarter-sized** hole in plastic and apply the wound vac connector.

Rotate to lithotomy position.
Once in lithotomy position, drape as follows: Green towels wrapped around leg with long axis of towels perpendicular to long axis of leg. Wrap the towels around the leg just proximal to the knee to cover the knees and upper portion of the yellow-fin stirrups. Pull leg drapes over legs and attach to green towels, leaving thighs free. Clean Green towels can then be placed over the thighs to keep the donor sites clean. Place ¾ drapes under abdomen and thighs to keep undersurface clean. Drape remainder of patient (abdomen, legs, etc.) in usual fashion using standard laparotomy drape.

Obtain grafts. After taking the graft, cover the thigh with epinephrine (If small area can use 1% lidocaine with 1:200,000 epinephrine on raytec)

Use 4’0’ monocryl on prepuce and labia if desired, however staples are fine too.

For lithotomy, need to apply a narrow skin graft in each lateral aspect of abdomen vertically and staple to the central piece to decrease tension on the sides of the abdomen. Then, cover graft over with Adaptic (Curity Non Adhering Dressing 5 x 9), then cut sponges in similar fashion and cover Adaptic (Curity Non Adhering Dressing 5 x 9) with sponges. Complete wound VAC in lithotomy.

When placing wound vac, to prevent further leaks around the Foley and the rectal tube use a Hollister urostomy wafer cushions over the initial wound vac plastic covering, stock number 7806. They keep them with the urology supplies. Cut a slit to the center and use the smaller one for the Foley, and the larger, one around the rectal tube (need to trim this one). Once sheeting is over and around the tubes and ostomy wafers, seal further with Coloplast Strip , followed by large sheets of vac sheeting with slits cut in the midline to allow draping around the tubes without kinking.

Set wound vac at 150 mm Hg continuous if large area involved. Can cover flaps with wound vac too.

Xeroform gauze to cover skin graft sites; Staple at corners. Place ABD over Xeroform, then Kerlex wrap and Ace bandage. (Remove Kerlex and ABD on POD 1 from thighs). Another option for wrapping the leg which worked nicely was to use xeroform gauze covered with ABD, then Kerlex, then cover with Bandnet 10” pack (precut Bandnet wrap). It is brought up over the heel and pulled up to the thigh

Consider 2 or more wound vacs (vulva and buttocks) if large area involved. To prep the area for wound vac:

WOUND VAC:

1) Make sure everything is dry, especially under the buttocks. Apply sticky plastic sheeting using ~1 inch strips around graft site in window pane fashion. This helps protect the skin and create a better seal.
2) Cut foam to fit Vulvectomy site. Silver-impregnated foam for OR 1 and first wound VAC change to improve antibacterial properties. Slits/holes are needed for the Foley and rectal tube.
3) Apply Mastisol (need at least 4) to the skin – this can even go over the window pane plastic. It’s especially important over the buttocks.
4) Apply Hollister wafer cushions around Foley and rectal tube after foam is covered with initial plastic sheeting for wound VAC. For the rectal tube, cut a slit in the Hollister waffer to open it, then enlarge the hole a bit. Apply it around the tube and overlap to create a better seal.
5) Use window paning technique around Hollister wafers to get better seal.
6) Have Coloplast Strip available to help seal wound VAC around Foley and rectal tube. The strip should also be placed in the gluteal cleft to allow for a better seal of the VAC sheeting into the buttocks region.
7) Put plastic sheeting/Tegaderms/etc. over foam to get good seals everywhere.
8) When ready to attach wound vac, cut a quarter-sized hole in plastic and apply the wound vac connector.
9) When starting suction, first deflate foam and remove as much air as possible using surgical suction (wall suction) canisters, and compress foam with hands to get as much air out as possible and get a better seal. Once the foam is essentially completely deflated, connect tubing to wound vac device.
10) Connect wound vac as above.

If any problems with wound VAC, can contact

Anthony Kann
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Make sure the Foley is draining at the correct angle
Make sure the rectal tube is at the correct angle. Irrigate with 60 cc water through Catheter irrigation port to make sure draining correctly

Once wound VAC draping is complete, apply wall suction to connector to remove as much air in the wound as possible and to look for leak sites. Once this is complete, clamp tubing and connect to VAC device, then unclamp and start suction.

10) For graft donor site, the entire site can be covered with Xerofoam. Staple at corners and remove staples on legs at time wound vac removed POD 5 after split thickness skin graft. Cover with ABD. Cover with Flexinet. Remove ABD and Flexinet one day after the grafts from the donor site.

Leave Xeroform to dry and trim away dry areas the come off of the skin.

Use heat lamp to thigh after ABD removed. One option is the Holmes Convention Heater with Thermostat, sold at Walgreens (#HFH111TU). If using this technique, after staples on thigh removed at time of wound vac removal, gradually cut off xeroform.

If doing flaps use 3’0’ vicryl buried stitches to reapproximate the skin through the dermis. Then close the skin with 3’0’ Nylon. The Nylon stitches should be removed in 3 weeks.

Remove Wound VAC after 5 days in operating room, and take out staples from vulva and buttock POD 14

For smaller grafts (vulva, but no mons or groins or buttock, the skin graft can be taken and no meshing done. Can use 3-0 chromic suture in an interrupted and in running fashion into the bilateral gluteal cleft and perianal region. A Reston bolster consisting of Xeroform, moistened cotton batting, and Reston staples can be used as a bolster to prevent motion or shear of the graft.

OR#4 (POD#5 after skin grafts)
Remove Wound VAC(s) in operating room. Irrigate wound VACS using a 60 cc syringe and (may need a catheter adapter (Christmas tree adapter) (blue one) Consider removing rectal tube and Foley versus leaving in for a day or two more.

On skin grafts, you may need to place Xeroform gauze (double layer) with Bacitracin touching the graft and areas that may not have taken and cover with Kerlex, followed by ABD, and stretchy underwear. If too wet, leave to air. Change the kerlex and ABD tid. Cut edges of Xeroform as it dries.

Cotton flushes

Burn net panties for compression

**OR 5 (on POD # 12-14 after skin grafts)**
Remove staples.
If there is excessive granulation tissue overlying healthy-appearing graft, consider scraping the graft down with a straight razor blade or scalpel (#10 or #15 blade). Electrocoagulate bed of granulation tissue with Bovie to obtain hemostasis and further cauterize the tissue.

**Post-operative Considerations**

1. Check wound cultures, check if bacteria resistant to present antibiotic. If sterile culture, consider discontinuing antibiotics.
2. Continue TPN
3. Sips and chips

Post-Op - They will need ongoing medical treatment for their hidradenitis after surgery.

**Orders OR 1 Vulvectomy Post-op Orders**

**Immediate Post-op**
- **If the specialty bed has not been delivered to the OR, again PAGE 7156 BEFORE the start of the case – again emphasize how important the bed is & that it must be delivered before the conclusion of the case.**

Admit to 8B
Service:
Attending:
Diagnosis: S/P Complete Radical Vulvectomy
Condition: Stable
Allergies:
Activity: Complete bedrest, do not elevate head of bed more than 20 degrees
VS: q 1 hour X 2, q 2 hour X 2, then q 4 hours
I/O’s q 4 hours
Diet-sips and chips
Hyperal
Start sliding scale

IV: D5NS with 20 meq/L KCl at 125 cc/hour, change to D5/0.45 NS with 20 meq/L KCL on POD#1, 80 cc/hr, decrease to KVO when tolerating po well
SCD’s on and functioning at all times
Incentive spirometry X 10 q 1 hour while awake
Instruct patient in cough and deep breathing, q 1 hour while awake
Physical therapy consult: supportive care while at bedrest, post-bedrest rehabilitation
Occupational therapy consult: activities for bedrest
Social work consult: home nursing needs, support

VAC Therapy Order: VAC machines, canisters and dressings to be placed at patient’s Bedside
Goal: Formation of granulation tissue in wound bed
VAC to be applied to vulva
Pressure setting: 150 mm Hg continuous if large area involved (if small area, 125 mm Hg)
Never leave subatmospheric pressure off or more than 2 hours per 24 hour period
Dressing will be changed POD 7 in the operating room
Bard Dignicare bowel system to closed drainage. Resident twice a day will, place patient in 15 degrees Trendelenburg and deflate the ballon (withdraw 45 cc from Balloon InflationPort; wait 5 minutes, then place back 45 cc sterile water). Do not disconnect the syringe from the bulb inflation/deflation port, in order to minimize the risk of introducing too much fluid into the bulb. After this, take out of Trendelenburg. Rectal tube can be flushed at both tube ports (labeled “IRRIG” and “FLUSH”) with 45 cc each sterile water or saline. The flushes should not be done with the bulb deflations. The patient does not need to be in the Trendelenburg position during tube flushes.

If buttock and vulva removed, patient to be rotated from left lateral position to right lateral position every 2 hours. When buttock involved, do not have patient lying on back. If only vulva removed, patient should be on back the entire time.

Foley catheter to gravity drainage, do not remove

Labs: CBCDP, Basic, iCal, Mg, Phos in am POD #1
(Consider labs in PACU depending on EBL/PRBC’s/pre-op Hct)
Medications:
  PCA: Start/Managed per Anesthesia, encourage epidural per anesthesia
  Toradol 30 mg IV X 24 hours, (use 15 mg if > 65 yrs or <50 kg,) change to PO Ibuprofen when tolerating PO well
  Neurontin
  Tylenol
  Ancef: 1 gram IV q 8 hours (May need revision when wound culture results available.)
  Diflucan 150 mg PO q week
  Heparin 5000 units SQ q 8 hours; D/C heparin 12 hours prior to OR 1 week later, and 12 hours prior to removal of wound vac 5 days after second surgery
FeSO4 325 mg PO daily
Tylenol 325-650 mg PO every 4-6 hours PRN mild pain/ headache (Not to Exceed 3000 mg/24 hours)
Benadryl 12.5-25 mg PO/IV q 6 hours PRN itching
Ambien 5-10 mg PO qhs PRN sleep
Phenergan 12.5-25 mg IV q 6 hours PRN nausea
Zantac 150 mg PO twice daily
Lomotil- Start on Lomotil up to qid a day before going for skin graft

OC’s:  continue if patient on preoperatively, consider other menstrual suppression
Tobacco service consult as indicated (No Nicotine containing products!)
[Encourage tobacco cessation preop]
(Review home medications and resume those indicated)
Notify H.O. (pager 0005):  temp > 100.4, SBP > 180 or < 80, DBP>95 or <50, HR >110 or < 60, UOP <120 cc/4 hours, dysfunction of VAC or rectal pouch, any sudden, rapid increase in bright, red blood in the tubing or canister of the VAC.

Make sure they have a specialty bed (“Sport” bed) The Sport bed is a low air loss bed that can be placed in Trendelenburg position for the rectal tube decompressions, etc.

**Orders OR 2 Post-op Wound Vac Removal**

(Same as above for OR 1 Post-op)

Admit to 8B
Service:
Attending:
Diagnosis:  S/P Complete Radical Vulvectomy
Condition:  Stable
Allergies:
Activity:  Complete bedrest, do not elevate head of bed more than 20 degrees
VS:  q 1 hour X 2, q 2 hour X 2, then q 4 hours
I/O’s q 4 hours
Diet-sips and chips
Hyperal
Start sliding scale

IV:  D5NS with 20 meq/L KCl at 125 cc/hour, change to D5/0.45 NS with 20 meq/L KCL on POD#1, 80 cc/hr, decrease to KVO when tolerating po well
SCD’s on and functioning at all times
Incentive spirometry X 10 q 1 hour while awake
Instruct patient in cough and deep breathing, q 1 hour while awake
Physical therapy consult:  supportive care while at bedrest, post-bedrest rehabilitation-mandatory arm and leg workouts should be agreed upon prior to surgery.
Occupational therapy consult: activities for bedrest
Social work consult: home nursing needs, support

VAC Therapy Order: VAC machines, canisters and dressings to be placed at patient’s Bedside
Goal: Formation of granulation tissue in wound bed
VAC to be applied to vulva
Pressure setting: 150 mm Hg continuous if large area involved (if small area, 125 mm Hg)
Never leave subatmospheric pressure off or more than 2 hours per 24 hour period
Dressing will be changed POD 7 in the operating room
Bard Dignicare bowel system to closed drainage.

Resident twice a day will, place patient in 15 degrees Trendelenburg and deflate the ballon (withdraw 45 cc from Balloon InflationPort; wait 5 minutes, then place back 45 cc sterile water). Do not disconnect the syringe from the bulb inflation/deflation port, in order to minimize the risk of introducing too much fluid into the bulb. After this, take out of Trendelenburg.
Rectal tube can be flushed at both tube ports (labeled “IRRIG” and “FLUSH”) with 45 cc each sterile water or saline. The flushes should not be done with the bulb deflations. The patient does not need to be in the Trendelenburg position during tube flushes.
If buttock and vulva removed, patient to be rotated from left lateral position to right lateral position every 2 hours. When buttock involved, do not have patient lying on back. If only vulva removed, patient should be on back the entire time.
Foley catheter to gravity drainage, do not remove
Labs: CBCDP, Basic, iCal, Mg, Phos in am POD #1
(Consider labs in PACU depending on EBL/PRBC’s/pre-op Hct)
Medications:
  PCA: Start/Managed per Anesthesia, encourage epidural per anesthesia
  Toradol 30 mg IV X 24 hours, (use 15 mg if > 65 yrs or <50 kg,) change to PO Ibuprofen when tolerating PO well
  Neurontin
  Tylenol
  Ancef: 1 gram IV q 8 hours (May need revision when wound culture results available.)
  Diflucan 150 mg PO q week
  Heparin 5000 units SQ q 8 hours; D/C heparin 12 hours prior to OR 1 week later, and 12 hours prior to removal of wound vac 5 days after second surgery
  FeSO4 325 mg PO daily
  Tylenol 325-650 mg PO every 4-6 hours PRN mild pain/ headache (Not to Exceed 3000 mg/24 hours)
  Benadryl 12.5- 25 mg PO/IV q 6 hours PRN itching
  Ambien 5-10 mg PO qhs PRN sleep
  Phenergan 12.5-25 mg IV q 6 hours PRN nausea
  Zantac 150 mg PO twice daily
  Lomotil- Start on Lomotil up to qid a day before going for skin graft
OC’s: continue if patient on preoperatively, consider other menstrual suppression
Tobacco service consult as indicated (No Nicotine containing products!)
[Encourage tobacco cessation preop]
(Review home medications and resume those indicated)
Notify H.O. (pager 0005): temp > 100.4, SBP > 180 or < 80, DBP>95 or <50, HR >110 or < 60, UOP <120 cc/4 hours, dysfunction of VAC or rectal pouch, any sudden, rapid increase in bright, red blood in the tubing or canister of the VAC.

Make sure they have a specialty bed (“Sport” bed) – page ostomy nurses day before surgery ideally in order to allow bed to be ordered and delivered to the OR. The Sport bed is a low air loss bed that can be placed in Trendelenburg position for the rectal tube decompressions, etc.

Orders OR 3 Post-op Skin Graft
Admit to 8B
Service:
Attending:
Diagnosis: S/P Vulvar skin graft
Condition: Stable
Allergies:
Activity: Complete bedrest, do not elevate head of bed more than 20 degrees
Patient to be rotated from left lateral position to right lateral position every 2 hours.

VS: q 1 hour X 2, q 2 hour X 2, then q 4 hours
I/O’s q 4 hours
Diet: sips and chips
Hyperal
Start sliding scale
IV: D5NS with 20 meq/L KCl at 125 cc/hour, change to D5/0.45 NS with 20 meq/L KCL on POD#1, 80 cc/hr, decrease to KVO when tolerating po well
SCD’s on and functioning at all times
Incentive spirometry q 1 hour while awake
Instruct patient in cough and deep breathing, q 1 hour while awake
VAC Therapy Order: VAC machine, canister and dressings to be placed at patient’s bedside
Goal: Formation of granulation tissue in wound bed
VAC to be applied to vulva
Pressure setting: 150 mm Hg continuous if large area involved (if small area 125 mm Hg)
Never leave subatmospheric pressure off or more than 2 hours per 24 hour period
Dressing will be changed POD 5 under conscious sedation or in operating room

Resident twice a day will, place patient in 15 degrees Trendelenburg and deflate the ballon (withdraw 45 cc from Balloon Inflation Port; wait 5 minutes, then place back 45 cc sterile water). Do not disconnect the syringe from the bulb inflation/deflation port, in order to minimize the risk of introducing too much fluid into the bulb. After this, take out of Trendelenburg.
Rectal tube can be flushed at both tube ports (labeled “IRRIG” and “FLUSH”) with 45 cc each sterile water or saline. The flushes should not be done with the bulb deflations. The patient does not need to be in the Trendelenburg position during tube flushes.
At other times, patient to be rotated from left lateral position to right lateral position every 2 hours. When buttock involved, do not have patient lying on back.

Abductor pillows
Foley catheter to gravity drainage, do not remove
Labs: CBCDP, Basic, iCal, Mg, Phos in am
(Consider labs in PACU depending on EBL/PRBC’s/pre-op Hct)
Medications: (Circle medications desired)
   PCA: Start/Managed per Anesthesia, encourage epidural per anesthesia
Toradol 30 mg IV X 24 hours, (use 15 mg if > 65 yrs or <50 kg,) change to PO Ibuprofen when tolerating PO well
   Ancef: 1 grams IV q 8 hours X 48 hours
   Diflucan 150 mg PO q week
   Heparin 5000 units SQ q 8 hours
   Lomotil –i po qid (NOT PRN), can decrease to tid, bid if needed.
   Neurontin 300 at bedtime
   FeSO4 325 mg PO daily
   Tylenol 325-650 mg PO every 4-6 hours PRN mild pain/ headache. (Not to Exceed 3000 mg/24 hours)
   Benadryl 12.5- 25 mg PO/IV q 6 hours PRN itching
   Ambien 5-10 mg PO qHS PRN sleep
   Phenergan 12.5-25 mg IV q 6 hours PRN nausea
   Zantac 150 mg PO twice daily
   OC’s: continue if patient on preoperatively, consider other menstrual suppression
   Tobacco service consult as indicated (No Nicotine containing products!)

Start to wean TPN one day prior to removal of WOUND VAC (cut in half for first day, then discontinue the next day). Check glucose 1 hour after TPN off.

Wound care for donor site (If wound vac not applied to donor sites, remove Kerlex and ABD 24 hours after surgery; leave on Xeroform –cut edges as they dry):

   After the outer dressing has been removed from the thigh, apply a heat lamp (100 W bulb, not closer than 18’) to the donor site for 15 minutes 3 times a day until dry (usually 1-2 days). If it starts burning, turn the lamp off or move it further away.
   Notify H.O. (pager 0005): temp > 100.4, SBP > 180 or < 80, DBP>95 or <50, HR >110 or < 60, UOP <120 cc/4 hours, dysfunction of VAC or rectal pouch, any sudden, rapid increase in bright, red blood in the tubing or canister of the VAC.
   Stop Heparin 12 hours before OR 3
   Bring down to OR on specialty bed

Orders Removal of Wound VAC

Turn off wound vac 30 minutes before removal planned. Need to order a Christmas tree to put on tube of wound vac. Use 30 cc syringe and inject saline about 30 minutes before removal planned.

Cover graft with Adaptic (Curity Non Adhering Dressing 5 x 9), then ABD then stretchy underwear. The following day, remove the Adaptic (Curity Non Adhering Dressing 5 x 9) from the graft and leave to air to dry. Leave Adaptic (Curity Non Adhering Dressing 5 x 9) on the thigh to dry and cut it as it dries.
New orders:
Consider leaving in rectal tube for a few more days, while TPN is being weaned. Start them on clear liquids to full liquid diet while rectal tube in during this time (the first 2 surgeries, keep NPO x chips and occasional sip)
D/C lomotil when rectal tube out
Advance diet
When rectal tube out- Milk of magnesia 30 cc po q 6 hours, when stools start, prn
Dressing changes-use saline to take off xeroform if needed. Do daily. Reapply xeroform with bacitracin daily, then cover with Kerlex, then an ABD.

Patient to remain in bed for 4 days. If large flap, will have gradual increase in sitting as follows:
The standard sitting protocol for these pts:
1) No weight bearing on buttocks for 3 weeks
2) Begin sitting protocol 15 mins TID for 2 days
3) Advance to 30 mins TID for 2 days
4) Advance to 45 mins TID for 2 days
5) Advance to 60 mins TID for 2 days
6) Continue with this advancement until she reached 120 mins TID and then she can sit without restrictions.
Rotate from left lateral position to right lateral position every 2 hours if flap in area of any pressure.

After each sitting time period, the buttocks is checked to make sure that the flaps are tolerating the sitting (erythema, venous congestion, stress at suture line, early wound separation).

Number of dressing changes per day: 2

D/C PICC line prior to home
Send home on Stage 1-2 hidradenitis regimen (antibiotics, OCPs, or spironolactone dependent on age).
Arrange for visiting nurse.

After the yellow Xeroform gauze has dried, lightly lubricate it daily with Vaseline.
Cocoa butter to thighs once the xeroform comes off

FOR HOME DRESSING CHANGES
DESCRIBE the dressing change process including number of each type of dressing product:
Using Toumy syringe and NS, irrigate all wounds. Apply ___# of xeroform gauze (5 x 9) impregnated with bacitracin to all wounds. Apply a middle layer of 4 inch kerlix (total of ___# of rolls) moistened with NS. Cover with ___# of Abd pads and hold in place with mesh panties.

Products needed to provide dressing changes as ordered for 1 month:
180 4 inch kerlix #6715
180 abd pads 8 x 10 #6715
10 mesh panties #SBXL100
10 boxes of 50 xeroform gauze #433605
60 blue pads
1 tube bacitracin #001116
1 box tongue depressors #WOD3005
1 tuomy syringe #30962

OR Scheduling

Preop  Psych, dietician, R/o Crohns

OR 1 Radical Vulvectomy Wound VAC

OR 2  Day 3  Wound VAC Change

OR 3  Day 7  Skin grafts, possible flaps, Wound VAC change

OR 4  Day 12  Wound VAC off

OR 5  DAY 21 Staple removal  can be done at EAST ANN ARBOR

Notes to print out on OR BOARD

Inform if prone to lithotomy (For prone, need gel pads, pillow and elbow protectors.)

THIS IS SIMILAR TO BURN PACK

Epi 1/1000

Ligasure

Wound VAC 125-150 continuous

Hollister urostomy wafer

DigniCare Rectal tube (Irrigate twice to check in place, once after placement and once at end of procedure)

Stryker irrigator

Xray bag

Mastisol ( need 4 or more for buttock and vulva each)

Adaptic (Curity Non Adhering Dressing 5 x 9)

12-17/1000 inch dermatome settingMesh 1.5 inch/1
Lorezepam may be needed if patient having problems with position changes

Tilt bed at time of taking patient off OR table…easier to roll

For Paget Disease, Wound Vac or cotton balls will stay on for 5 days. Consider suturing if smaller area so that second OR not required. Smaller areas with wound VAC or cotton balls can be removed at bedside.