

Editorial



In these ever-changing and exciting times in medicine there appears to be a shift towards shared responsibility for the management of patients. The multidisciplinary approach to complex problems such as cancer or congenital abnormalities has been the standard of care for

some time now. For example, in head and neck cancer, a team comprising a head and neck surgeon, plastic and reconstructive surgeon, radiation oncologist, speech therapist, dietician etc., is a minimum requirement in most academic centres.

The field of wound care has unfortunately been one of the least glamorous areas in medicine. For this and other reasons, many doctors are only too glad to offload their patient with a chronic wound to a wound care nurse. Other reasons include a lack of wound care knowledge, poor remuneration for wound care and the prolonged time that each dressing change may take. Not to mention the fact that these patients are difficult to manage because they usually have other comorbidities and are often depressed.

The same is not true for the wound care nurse. This work is their passion and primary source of income and they take great pride in what they do. They are usually very well-educated about wound care and dressings and, on the whole, do fantastic jobs at getting difficult wounds to heal. There have been the occasional cases where the patient is “held onto” for a little too long before help is sought from other specialities. Many cases are only referred after 6 months or more. Often times it is not because the nurse wants to hold onto a patient but because the primary overseeing doctor does not seek alternative help.

Most would agree that any complex wound (chronic wounds included) should be treated no differently to cancer or any other

pathology that requires a multidisciplinary approach. Complex wounds are invariably a multidisciplinary problem, often requiring the care of a vascular surgeon, diabetic specialist, plastic surgeon, dietician, podiatrist, psychologist etc. Yet, multidisciplinary meetings to discuss patients with complex wounds are non-existent or very rare. Why is this pathological entity treated differently, given the huge numbers of patients that are affected by complex wounds? These wounds place enormous social and financial strain on these patients and their families, their careers and our healthcare system. In the United States, chronic wounds cost the country 50 billion USD per annum, ten times more than the WHO’s entire annual budget!

Multidisciplinary wound clinics are becoming standard of care in many countries and have shown astounding improvements in patient care, dropping diabetic amputation rates from 53% to 16% in one study. I believe that South Africa should follow suit and hope to see many more of these clinics in the future.

In this issue, we see some interesting articles on the management of complex wounds, such as Fournier’s gangrene, burns and the surgical defects left by the resection of a dermatofibrosarcoma. There are some interesting case reports on the benefits of Sorbion. Lastly, there are two reprinted articles on NPWT, one of which was the first of a series of publications which revolutionised our understanding of the mechanism of action of NPWT.

Lastly, it gives me great pleasure to announce that Dr Maria Giaquinto-Cilliers, a plastic surgeon and diligent member of my Editorial Board, has assumed the more involved role of Associate Editor, alongside our existing Associate Editor, Hiske Smart. I am delighted and privileged to be surrounded by such enthusiasm, which will help take this journal to new heights.

I hope you enjoy reading this issue and take away some new knowledge in doing so.

Nick Kairinos

Erratum: In the article entitled “Practice of negative pressure wound therapy (NPWT) in Togo” published in *Wound Healing Southern Africa* 2016;9(2):15-17, the main refers to a prospective study being performed but this should in fact be a retrospective study.