Letters and comments

Topical steroids for chronic wounds displaying abnormal inflammation

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COMMENT ON

Bosanquet DC, Rangaraj A, Richards AJ *et al*. Topical steroids for chronic wounds displaying abnormal inflammation. *Ann R Coll Surg Engl* 2013; **95**: 291–296
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We read with interest this retrospective study by Bosanquet *et al*. They concluded from their analysis on 34 wounds identified from 25 individual patients that Trimovate® (GlaxoSmithKline, Uxbridge, UK) generally promotes wound healing in a cohort of patients with chronic wounds with clinical evidence of excessive inflammation. It highlighted several issues that we feel are important to the many clinicians who deal on a regular basis with wounds that are difficult to manage. As this was a retrospective review looking at a tiny proportion of the patients treated in their centre with patients having differing aetiologies, it would be inappropriate to use the statistical approach they have adopted.

There are major concerns regarding study design that warrant the reader to question the reliability of their findings. Bosanquet *et al* have discussed the lack of a comparison group, which is a major limitation of this study. The lack of a comparison group also makes it difficult to draw any conclusions on the benefits of Trimovate®. The series of patients they describe and the lack of any routine approach to their wound management introduce far too many variables for clinicians to gain any understanding of the role Trimovate® has in the management of chronic wounds. This is especially relevant when considering the indication for Trimovate®.

The authors state that Trimovate® was started by a senior wound care physician 'in cases where the wound base was thought to show excessive inflammation'. This is a rather loosely defined baseline to start application of Trimovate® with no standardised measure of inflammation indicated. We wonder if it was simply an arbitrary decision. Although they have specified their inclusion and exclusion criteria, they have not mentioned specifically whether other interventions were used such as compression bandaging or whether the Trimovate® was used by itself or in combination with other simple dressings such as Jelonet® (Smith & Nephew, Hull, UK). It is hard to believe that Trimovate® would be used as the sole intervention in these challenging cases.

We also note that despite discussing the potential effects of fungi and bacteria on the wound, no data are provided on the bacteriology of these wounds. This would surely be important when using an antimicrobial, particularly if one were to try to gauge the potential benefits of antifungals, antibacterials and steroids on their own. The authors quite rightly point out that there is little evidence to support the use of steroid combinations and we would suggest that their data do not provide any more useful evidence.

The use of topical steroids on their own or in combination with antimicrobials is an important area. Many use these products for overgranulated wounds or as second line treatment for recalcitrant wounds. Many patients are therefore treated with these products without knowing whether they are indeed being given a beneficial treatment. We would encourage the authors to address this deficiency with well designed and well powered trials so that patients can be treated appropriately.

Authors' Response

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We are very grateful for the interest Nikkhah and Dheansa have shown in our paper, and thank them for their comments and questions. We make no secret of the limitations of a retrospective case series evaluating a multiagent topical product on a heterogeneous group of wounds and patients, with a differing length of follow-up period. Our discussion has already covered a number of Nikkhah and Dheansa's concerns, and we were deliberately careful to avoid over-zealous conclusions from such an inherently limited data set. However, in the almost complete absence of published data on topical steroids for chronic wounds, we felt compelled to distribute our outcome data for a product that we have, during our treatment of over 1,500 patients with wounds per year, found to be a useful adjunct to standard wound care in specific cases of hard-to-heal wounds.

A few specific responses are warranted. The decision to treat with a combined topical steroid, antifungal and antimicrobial preparation was, as has been pointed out, arbitrary in that there were no hard data to support this decision making. No standardised measure exists by which inflammation can be assessed although its visual characteristics of 'beefy red' granulation tissue are well recognised by clinicians

experienced in this field. Our statement that 'other dressings, topical treatments and compression garments were prescribed as appropriate' was kept deliberately vague as ulcers of different aetiologies were managed with different dressings and compression regimes although we can reassure Nikkhah and Dheansa that non-adherent dressings were almost always placed over the topical treatment after its application.

Our unit does not use antimicrobial swabs routinely in the management of wounds. Instead, we reserve them for cases where initial antibiotic therapy has failed to eradicate a spreading infection. However, we agree that microbiology

data would be of some benefit in identifying which patients would benefit from this topical treatment.

We take issue with Nikkhah and Dheansa's conclusion that our findings provide clinicians with no further useful data. They make the point that many clinicians use these products for a variety of wounds despite a seriously lacking evidence base. While we are far from suggesting that this be viewed as a panacea, we do suggest that in certain cases (and given certain provisos), a combined topical steroid, antifungal and antimicrobial preparation can be considered a useful tool in the ongoing treatment of recalcitrant wounds.

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