Nurse specialists and surgeons were among the keynote speakers at our conference aimed at driving improved trauma aftercare for ex-military men and women. The Woundcare4heroes (WC4H) conference, ‘Making holistic care a reality for patients with complex traumatic wounds’ on 13 October in London was hosted by Stoll, a veterans’ housing charity. Scar, burn and post-amputation management were on the agenda, as well as mental wellbeing and antibiotic-sparing, topical treatments.

**Lt Col Tania Cubison**

Lt Col Tania Cubison is an Army consultant plastic surgeon based at the Queen Victoria Hospital NHS Trust at East Grinstead. While many patients will be left with a satisfactory residual limb after amputation, others have ongoing problems. ‘Usually this will manifest as pain or poor prosthetic fit,’ said Tania, who also works at the McIndoe Centre, a private hospital that does work for Headley Court, the armed forces rehabilitation centre. Referring to Afghanistan, Tania said: ‘The new thing specific to this conflict was the horrendous lower limb injuries associated with improvised explosive devices (IEDs).’

The surgeon operated on 104 patients with 126 stumps between 2009 and 2013. Most were military, 86% were male and there was a high number of double amputees. Heterotopic bone, or the presence of bone in soft tissue where bone normally does not exist, was linked with high energy injuries. ‘The bigger the blast, the more abnormal bone you get.’

In 2016, Tania operated on 40 patients, all civilian, with heterotopic bone after high energy injury. She said conventional wisdom is to leave spikes but they can cause pain and work their way through skin. ‘This is not princess and the pea stuff, it has got to come out. It only takes a small spike to make a lot of discomfort for the patient,’ said Tania, adding: ‘These are things I have learned not by reading books but by treating patients.’

Delegates heard amputee patients can also be left with sensitive nerve ends, or neuroma, on the end of their stump ‘quashed every time they put a socket on’ for their prosthetic limb. Tania said residual limb pain is complex and the cause is often unclear or multifactorial, but sometimes the problem has a definite anatomical basis. In these cases, surgery may help. ‘Stop and remove the stone from your shoe rather than taking paracetamol,’ said the plastic surgeon.

Good indications for surgery include bone spikes, neuroma, unstable scar, foreign bodies and major soft tissue excess. The benefits are less clear in cases of recurrent, more proximal neuromata or minimal soft tissue excess. She warned residual limb or stump surgery is complex and there is always a risk of exacerbating phantom limb pain. ‘Some do very well and some very badly. I have a few patients I have undoubtedly made worse.’

Careful assessment is needed and a multidisciplinary approach is essential for good patient outcomes.

**Major Keith Moore**

Major Keith Moore, a clinical nurse specialist in tissue viability, works within primary care in the north-west of England and is a nursing officer in a Territorial Army Field Hospital. His military career started as a solider in the Parachute Regiment and his most recent deployments were to Iraq and Afghanistan.

Keith, a WC4H trustee, spoke about the transitional and long-term considerations for the management of veterans with complex post-traumatic wound injury. He posed the question: are military wounds different?

Delegates saw slides of ex-military patients with combat-related invasive fungal mould infections following explosive blast injuries, including, aspergillus. ‘Some problems can happen 5 or 10 years down the line. How many nurses ask patients if they served in the military?’

He cited the example of a 96-year-old man who fought in Burma during the Second World War and had suffered with leg ulcers for 15 years. After years of antibiotics, compression and topical treatments, it was discovered he had shrapnel in his legs. ‘Sometimes that little five-minute talk will give you a lot of information.’

Many GPs have very little experience of dealing with post-traumatic wound injury, said Keith, adding there is ‘help out there’ from charities such as WC4H, which can get rapid referrals to specialists, advise on wound management and access specialist equipment.

**Mr Shehan Hettiaratchy**

Shehan Hettiaratchy, lead surgeon and major trauma director at Imperial College Healthcare NHS Trust, spoke about a new Veterans Trauma Network (VTN) he co-founded in 2016 to better meet the medical needs of veterans.

Previously, there were ‘no formal mechanisms for dealing with veterans in the NHS,’ said Shehan, a member of the British Army
reserve who was twice deployed to Afghanistan. The VTN dealt with 50 patients in its first year and numbers are expected to grow.

The network consists of 10 regions that align with major NHS trauma centres. Most have military personnel, regular or reservists, working as part of the NHS team, which gives them insight into dealing with the delayed consequences of combat-related injuries.

Shehan said there was no prioritisation for veterans over NHS patients or special care, but it meant ex-military men and women would see clinicians who know how to treat their problems. He said a strong partnership had been forged between military care and the NHS in the last 10–15 years. ‘So veterans get the people who kept them alive in the battlefield looking after them in the NHS.’

‘It is not just how much trauma they have experienced, but how they process that and what has led them to this point,’ said Cassandra.

She outlined the key elements of the service as transition for those approaching discharge; intervention for those with more complex needs and liaison or signposting to appropriate NHS and third-sector or charity services.

Other speakers included Jonathan Reinarz, Professor of the History at the University of Birmingham who looked at the history of burns treatment in Britain, and Dr Yamni Nigam, Associate Professor at Swansea University, who presented the latest scientific and clinical evidence for the use of topical maggot therapy on wounds, an antibiotic-sparing treatment.

Jacky Edwards

Jacky Edwards, the UK’s first burns nurse consultant, runs two scar clinics at Wythenshawe Hospital in Manchester. She told delegates that the management of scars is ‘highly challenging’ as no single treatment is highly effective.

Preventative scar management includes moisturising skin to make it more malleable, massage to break down collagen fibres and sun protection to prevent skin staining and permanent pigment alteration. The scar that forms depends on the type of injury, size and depth of the wound, and the body part affected.

Problems include itching, sleepless nights and very dry skin. Scars have ‘much in common with eczema’, said Jacky, a lecturer practitioner in burns, plastic surgery and tissue viability at Manchester University.

Hypertrophic scars present as deep red to purple in colour and become more elevated, firm, warm to the touch and itchy as the scar progresses. ‘It is more efficient to prevent hypertrophic scars than to treat them,’ said Jacky. Early diagnosis of a problem scar can lead to better outcomes, but patients are often discharged with no follow-up.

‘Nurses and health care practitioners need to be as knowledgeable about scar products as they are about wound products and their responsibility should not end once the wound has healed,’ said Jacky.

Jacky reviewed various scar treatments including silicone gels, laser therapy and pressure garments. Late scar management options include surgery, but it is not a decision taken lightly. ‘Potential for abnormal scarring is high… if patient has developed a hypertrophic scarring once, the potential is high they could again.’

Claire Stephens

Claire Stephens, co-founder and chief executive of WC4H, described how the charity was set up 5 years ago to help ex-military men and women access ongoing medical care throughout their civilian life. Under the charity’s 5-year strategic plan 2017–2022, it will continue to offer services and support to veterans with complex wound management needs in England and Wales, as well as their families and health teams.

Referring to the NHS and charity sector, she said: ‘I think the only way we can make a difference is if we all work together. Some of our best outcomes have been joint working with local GPs and nurses within various clinical care groups, offering training, easy access and support.’

Claire, a nurse specialist and former Nursing Officer Captain of Queen Alexandra’s Royal Army Nursing Corps, told delegates who were mostly nurses: ‘If you need our help, please ask… if you have a gap in care to be filled we will genuinely strive to help you fill that gap.’

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Jackie Stephen-Haynes

Speaking after the conference, Professor Jackie Stephen-Haynes, who chaired the event, said: ‘The speakers were without exception all excellent.

‘Tania Cubison talked with real energy and passion about the pain in amputation stumps and demonstrated what can and sometimes cannot be achieved. Major Keith Moore’s presentation on the long-term management strategies for post-traumatic wounds highlighted the challenge for veterans — and the importance of better knowledge, of thinking holistically and differently and of listening more carefully.

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Society update

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