

## Market Insights: Advanced technologies for the WHOLE patient.



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Dr Regulski is also a Co-Director of The Center for Wound Healing & Hyperbaric Medicine at Community Medical Centre. His experience includes being the principal investigator for clinical trials in wound healing and has published several articles for the treatment of chronic wound healing and limb-salvage surgery.

Wound Market Consulting has embarked upon a short series of interviews of international clinicians to provide an insight into how they prioritise advanced technologies. Our first interview is from America, with Dr Regulski, DPM, F.F.P.M. RCPS (Glasg) Medical Director of the Wound Care Institute of Ocean County New Jersey, USA.

Asked what were the five most important factors (out of the many) determining the healing of a complex wound, Dr.Regulski didn't surprise by listing 1) an accurate and holistic diagnosis starting with determining blood flow, 2) disrupting the biofilm as 90% - 95% of chronic and 6% of acute wounds have biofilm-related infections and addressing infection, 3) putting appropriate ancillary therapies in place depending upon the wound aetiology such as offloading with a total contact cast or CAM boot or multi-layer compression 4) achieving patient concordance with the care plan including nutrition, diabetes control and lifestyle issues such as smoking and then, after all of these, 5) the consideration of an advanced technology, if indeed needed by then.

Working in a referral centre, Dr.Regulski is presented with patients who have already received some form of wound treatment beforehand. US Health Insurance policies require that when treating a chronic wound, the clinician can only move to an advanced cellular therapy if there is documentation to evidence that wound healing has failed to progress in four weeks for a diabetic foot ulcer and twelve weeks for a venous leg ulcer.

Like many specialists worldwide, whilst deeply interested to know the previous treatment he applies best practice standard care on the basis of his diagnosis for the four or twelve weeks stipulated by US Insurances as the period of standard treatment required before considering cellular therapies. Standard wound care in this case means biofilm disruption and reduction of inflammation with a product such as BlastX (Next Science) followed by a collagen and the appropriate dressings for highly exuding wounds, only then, if progress is not satisfactory, an autologous graft or an advanced cellular therapy. These latter are now used in about 10-15% of wounds. The cellular therapies used are Grafix (Smith & Nephew), Apligraf (Organogenesis) and AlloPatch (MTF). The number of cases of grafts and cellular therapies have dropped by more than half since Dr.Regulski has had effective tools with which to deal with biofilms.

Unlike in some European countries, he is in the fortunate position of remaining the patient's clinician for the entire duration of the wound treatment. The patient has continuity of care and Dr Regulski is able to monitor the wound's progress at first hand and evaluate objectively the effectiveness of the products he is using. This is in contrast to the position of specialists in some European healthcare systems where they make the diagnosis, set the care plan but may not, for budgetary and organisational reasons, be able to follow the patient to ultimate wound healing, making it more difficult for them to judge the efficacy of technologies used out from under their control.

We asked Dr.Regulski what was his one most important message to the innovators and developers of the wound care industry. It was that, irrespective of the mode of action of advanced wound care technologies and, no matter how good they genuinely are in themselves, the crucial factors when considering wound care treatment are accurate diagnosis, patient concordance and wound bed preparation. New technologies should be designed with these in mind to take into account, to use the popular phrase, "the whole patient and not just the hole in the patient".