McKESSON

McKesson

WoundCare Companion™

Pocket Guide

Guide reference

Advanced Skin and Wound Care Solutions

Clinical Support/Education

Prevention

Treatment

Advanced skin and wound care solutions

Advanced skin and wound care solutions

At McKesson, we understand how complicated advanced wound care can be. We are dedicated to making it easier by providing you with a robust portfolio of products that allows you to choose the right solutions for your patients, and your business. Plus, access our clinical support teams, self-serve resources, educational webinars and more, to discover why McKesson is your single partner for simplifying your wound care needs.

Educational support

This instructional Pocket Guide is provided to assist you with the challenges of wound care, focusing on the areas listed below:

- Skin Assessment
- Wound Assessment
  - Wound Prevention
  - Wound care Resources
- Product selection guides for advanced skin and wound care

Advanced skin and wound care solutions

Clinical support

McKesson's Clinical Resource Team of experienced clinicians can help provide:

- Clinical support and educational resources
- Educational webinars hosted by our clinical team and leading manufacturers
- Product standardization and formulary development
- Gain access to McKesson Academy™, a no-cost learning portal. — **mms.mckesson.com/mckesson-academy**

Business support

Our comprehensive product offerings can help make caring for wounds easier and more cost effective. Our portfolio includes:

- McKesson SpendManager℠
- Customer business reviews
- Connectivity/insurance billing solutions
- Shipping and distribution solutions
- Patient home delivery*
- Consultative support
- ORBITS®

Refer to the **Product Resource Guide** for more details of our product offerings for advanced skin and wound care.

*Only available for properly licensed customers.

Advanced skin and wound care solutions

Advanced skin care

Healthier skin means healthier patients and residents, as well as improved clinical outcomes. Our skin care products provide a first line of defense against skin issues and irritations.

McKesson offers comprehensive advanced skin care products that can help you address a variety of skin care needs, including:

- Cleansing
- Moisturizing
- Protecting[1]
- Preventing skin breakdown
- Treating

Advanced skin and wound care solutions

Advanced wound care

Our comprehensive product offerings can help make caring for wounds easier and more cost effective. Our portfolio includes:

McKesson offers comprehensive wound care products including:

Adhesive and non-adhesive foams	MEDIHONEY®[10]
Adhesive removers	Multi-layer compression bandages
Antimicrobial products	Negative pressure wound therapy
Bordered gauze	No sting liquid film skin protectors
Calcium alginates and gelling fiber dressings	Silicone adhesive foams
Collagens	Specialty absorptive dressings
Composite dressings	Transparent films
Contact layers	Unna boots
Hydrocolloids	Wound cleansers
Hydrophilic wound dressings	Wound measuring guides
Hydrogels	Xeroform

Visit **mms.mckesson.com/resources/wound-care,** to find more resources, including our **Product Resource Guide** for additional information about our advanced wound care solutions.

Advanced skin and wound care solutions

Swift Medical | SWIFT

McKesson is working with Swift Medical, the leader in digital wound care technology, to transform mobile devices into medical grade technologies to make high-quality care accessible to more patients.

The Swift Skin and Wound mobile solution provides AI-powered imaging capabilities to capture clinically validated, high precision 2D and 3D images, measurements and other clinical data to help clinicians and patients track skin or wound conditions.

Swift Medical's technology is trusted by over 20,000 clinical users across North America, from home health organizations, skilled nursing facilities, hospitals, wound care clinics, pharmaceutical companies and academic institutions.

Proven clinical, operational and economic outcomes supported by the most powerful wound image dataset in the world:

37% improvement in wound healing times[2]

14% reduction in hospitalizations[3]

35% reduction in wound prevalence[4]

Swift Medical has partnered with the leading EMR/EHR providers in every care setting to ensure clinicians have a seamless user experience that is fully integrated with their workflows.

To learn more visit **https://mck.ink/swift-wound-24**

Clinical support/ education

Clinical support/education

Assessing the skin

What is healthy skin?

Skin is composed of two main layers, the epidermis and the dermis. The epidermis is the outer most layer which acts as a barrier to pathogens and helps regulate water loss.

Healthy skin is characterized as:

Intact

Even skin color

Supple

Clean

Normal body temperature

Hydrated

Skin conditions

Intact, dry

The epidermis lacks moisture or sebum, often characterized by a pattern of fine lines, scaling and itching.

Flaky, cracked

The skin lacks adequate moisture or sebum resulting in excessive drying of the skin, leading to flaking of the epidermis, cracks and fissures that may extend into the dermis. Cracks in the skin may result in portals for infection.

Bruising/ecchymosis/purpura

Discoloration of the skin due to trauma or damage causing blood to pool under the skin.

Skin conditions

Erythema

Superficial reddening of the skin. May appear differently across different skin tones. [5]

Wet, macerated, denuded

Wet or macerated skin results from prolonged exposure to moisture. If the skin is not protected from moisture, it may lead to denudement. Denuded skin results from the loss of the epidermis, causing partial thickness breakdown of the skin into the dermis. The denuded area is reddish-pink in color. [5]

Skin conditions

Intertriginous areas

Intertriginous is a term used to define an area where two skin areas may touch or rub together. Moisture can be trapped in these areas, which can lead to fungal infections and/or skin breakdown.[6]

Fungal rash

Signs and symptoms of fungal rash may include redness with darker pinpoint lesions, severe itching, burning, soreness and irritation. Impairment of the integrity of the skin due to moisture is a common contributing factor.

Clinical support/education

Assessing wounds

Elements of wound assessment

Accurate documentation: Document according to agency or facility policy and procedure so progress to goals can be determined. Accurately document findings.

Classification: Stage (for pressure injuries); full or partial thickness.

Drainage: None, minimal, moderate, copious. Serous, serosanguineous, sanguineous, purulent, color and consistency.

Etiology: Pressure, venous, diabetic, arterial, surgical, traumatic.

Location: Refers to specific body part or bony prominence over which the wound is located.

Measurement: Length x width x depth in centimeters. Assess for undermining and tunneling.

Pain: Assess for pain related to the wound in general, as well as how it relates to the treatment or dressing change. Use a pain scale to get a more quantitative assessment.

Signs of infection: Erythema, edema, induration, fever, streaking, increased drainage, odor, warmth, malaise, weeping, increased pain, discolorations, delayed healing, change in color, absent or abnormal granulation tissue.[5]

Surrounding tissue: Color, edema, firmness, intact, induration, pallor, lesions, texture, scar, rash, staining, moisture/macerated.[7]

Wound bed: Cleanse prior to assessment. Determine tissue type (granulation, slough, eschar, epithelial, anatomical structures) and the percentage of each tissue type.

Wound edges: Defined or undefined edges; attached or unattached edges; rolled under (epibole), macerated, fibrotic, callused border shape.[7]

Wound depth description

Although there are many different etiologies of wounds, they can all be classified as either partial or full thickness to indicate the depth of tissue damage.

Partial thickness wound

Confined to the superficial skin layers; damage does not penetrate below the dermis and may be limited to the epidermal layers only.[8]

Full thickness wound

Tissue damage extending through the dermis to involve subcutaneous tissue and possibly muscle/bone.[8]

Healthy tissue

Granulation tissue

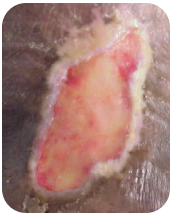
The pink/red moist tissue composed of new blood vessels, connective tissue, fibroblasts and inflammatory cells, which fills an open wound when it starts to heal; typically appears with an irregular, granular surface.[7]

Epithelial tissue

Originates from the wound margins to re-surface the wound. The new epithelial tissue appears as light pink with a shiny pearl appearance. Epithelialization is the process of the epidermis regenerating across a wound surface. Once the epithelium is created it and covers the wound bed it becomes stronger over time.[7]

Necrotic tissue

Necrotic tissue in a wound is typically referred to as either slough or eschar.



Slough

Non-viable tissue seen in full thickness wounds. Hydrated necrotic tissue, color varies including: yellow, gray, tan and brown. Soft and thin, fibrinous, stringy or mucinous.[8]

Eschar

Non-viable tissue seen in full thickness wounds. Dry necrotic tissue; firm leathery, black/brown appearance. As eschar is moistened, it slowly turns to slough.[7]

Debridement

Autolytic debridement

Debridement is the removal of necrotic or devitalized tissue from the wound bed. The presence of necrotic tissue increases the risk for bacterial growth and infection, and its presence generally impairs the natural healing process. The most common methods of debridement include autolytic, enzymatic and mechanical.

Removal of devitalized tissue can be accomplished by the use of moisture retentive dressings. Maintaining a moist wound environment and moisture balance will facilitate the body's own enzymes and white blood cells in the debridement of necrotic tissue. Advanced wound care dressings that promote moist wound healing are effectively used to facilitate and enhance autolytic debridement.[8]

When not to debride

When pressure injuries are located on the heel, ear, foot, or other site with little subcutaneous or muscle tissue and are covered with a dry, stable eschar, they typically should not be debrided.

Debridement is also generally not recommended for arterial ulcers and diabetic ulcers with dry eschar or dry gangrene, without infection and with an insufficient vascular supply for healing, unless circulation to the area can be improved.[9]

Wound infection

A wound is considered infected when replicating organisms invade the tissues and a host immune response is detected. The only way to definitively determine infection is with a wound culture or tissue biopsy. In some patients, the response to infection may be subtle. Signs may include hypergranulation, friable tissue, worsening pain, increased drainage and delayed healing. Often, chronic wounds have an aggregate of bacteria known as a biofilm which can impair wound healing.

Clinical signs and symptoms of infection

Pain: Increased pain at the wound site.[5]

Erythema: The presence of bright or dark red skin or darkening of normal skin color immediately adjacent to the ulcer.[7]

Edema: The presence of shiny taut skin or pitting impressions in the skin adjacent to the ulcer.[7]

Heat/warmth: A detectable increase in temperature of the skin adjacent to the ulcer.[7]

Drainage: Increase in any type of drainage.[7]

Foul Odor: Assess for odor after cleansing the wound thoroughly.[7]

Delayed healing: An absence of change or an increase in volume or surface area of the ulcer over the preceding two weeks.[7]

Wound documentation tips

Wound documentation tips

Include summary of the following in wound assessment documentation[7].

1. **Wound assessment findings**
   Shape, type of wound, partial or full thickness, wound bed tissue types and amount, wound edges, measurements – Length X Width X Depth, surrounding tissue, drainage type and amount, odor, undermining, tunneling
2. **Patient's mobility status**
3. **Positioning/turning devices available**
   Pillows and splints
4. **Positioning limitations**
5. **Nutritional status**
6. **Nutritional supplements**
   Vitamins, supplements, appetite stimulants
7. **Continence**
   Management plan, bowel bladder training, skin barriers, catheters, medications
8. **Type of support surface bed/chair**
9. **Abnormal labs**
10. **Infections**
    Fever, increased white count, hypotension, general malaise, redness, swelling, induration, streaking, purulent drainage, edema, warmth, pain at site

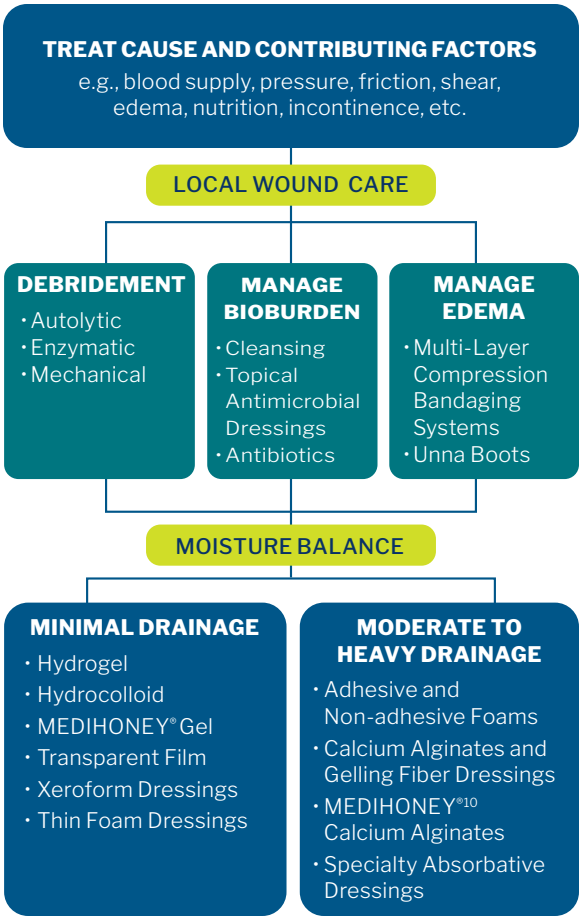
Wound documentation tips | *continued*

11. **Circulatory**
    Status pulses, capillary refill, ankle brachial index, edema, measurements of calf and ankle
12. **Pain on dressing change**
13. **Medications altering healing**
14. **Deterioration of medical condition**
15. **Current topical treatment plan**
16. **Response to care/treatment plan**
    Changes in the wound size, experiences pain upon dressing change, patient non-compliant, adverse reactions
17. **Modifications to care**
    Document changes to plan of care based upon findings
18. **Implementation of orders**
    Document when new orders are received and carried out
19. **Referrals**
    Dietary, clinical nurse specialists, physical therapy, surgeon, podiatry, wound specialist, nurse, dentist
20. **Compliance with care plan**
21. **Patient/family/staff education**
22. **Physician/nurse practitioner notification**
23. **Family notification as warranted**

Identifying a treatment plan

On the next page, you will find an algorithm for identifying a treatment plan.

Identifying a treatment plan



Clinical support/education

Wound Types

Pressure injuries

A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.[11]

Pressure injuries: Stage 1

Stage 1: Non-blanchable erythema

Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin.

Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.[11]

Pressure injuries: Stage 1 | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, non-blanchable redness, pain, firm, soft, warm or cool.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear.
Cleanse wound and prepare and protect peri-wound skin	Gently cleanse during routine bathing and pat dry.
Apply primary and secondary dressing as needed	Typically no dressing is required; Do not massage the area. If a dressing is desired, options may include no-sting skin barrier, transparent film, hydrocolloid, or multi-layered, bordered silicone foam.
Considerations	In the presence of excessive moisture, consider use of a skin barrier or protectant.

Pressure injuries: Stage 2

Stage 2: Partial thickness skin loss

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.

These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).[11]

Pressure injuries: Stage 2 | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, tissue type, drainage amount and character, peri-wound skin. Assess for signs and symptoms of infection to include pain, erythema, edema, heat/warmth, increased and/or purulent drainage, foul odor and delayed healing.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear.
Cleanse wound and prepare and protect peri-wound skin	Cleanse with saline or wound cleanser and pat dry.

Pressure injuries: Stage 2 | *continued*

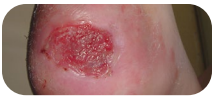
STEP	ASSESSMENT AND SUGGESTED ACTIONS
Apply primary and secondary dressing as needed	**Minimal drainage:** Consider using a dressing that promotes moist wound healing, such as: Xeroform, hydrogel, or hydrophilic wound dressing covered with appropriate secondary dressing such as bordered gauze, composite dressing or non-adherent dressing secured with roll gauze. Or, consider using a thin silicone bordered foam or hydrocolloid dressing. **Moderate to heavy amount of drainage:** Consider using a dressing which absorbs drainage, such as: calcium alginate, gelling fiber, specialty absorptive dressing, or foam. If a secondary dressing is necessary, consider a silicone bordered foam.

Pressure injuries: Stage 3

Stage 3: Full thickness skin loss

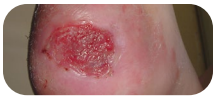
Full-thickness loss of skin, in which adipose (fat) may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.[11]

Pressure injuries: Stage 3 | *continued*



STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, tissue type, drainage amount and character, peri-wound skin. Assess for signs and symptoms of infection to include pain, erythema, edema, heat/warmth, increased and/or purulent drainage, foul odor and delayed healing.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear.
Cleanse wound and prepare and protect peri-wound skin	Cleanse with saline or wound cleanser and pat dry.

Pressure injuries: Stage 3 | *continued*



STEP	ASSESSMENT AND SUGGESTED ACTIONS
Apply primary and secondary dressing as needed	**Minimal drainage:** Consider using a dressing that promotes moist wound healing, such as: Xeroform, hydrogel, hydrophilic wound dressing, hydrocolloid, thin silicone foam, or MEDIHONEY® Hydrogel, Gel or Paste. If a secondary dressing is necessary, consider bordered gauze, composite dressing, or non-adherent dressing secured with rolled gauze. **Moderate to heavy amount of drainage:** Consider a dressing which absorbs moisture. Loosely fill any depth with calcium alginate, gelling fiber, or MEDIHONEY® Alginate. If a secondary dressing is necessary, consider a silicone bordered foam or specialty absorptive dressing. If needed, secure with rolled gauze or stretch net.
Considerations	If contamination is suspected, consider using antimicrobial treatments. If wound healing is slow or stalled, consider adding collagen when the wound base is free of necrotic tissue. Assess for appropriateness of debridement and refer to prescribing authority according to agency or facility policy.

Pressure injuries: Stage 4

Stage 4: Full thickness tissue loss

Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.[11]

Pressure injuries: Stage 4 | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, tissue type, drainage amount and character, peri-wound skin. Assess for signs and symptoms of infection to include pain, erythema, edema, heat/warmth, increased and/or purulent drainage, foul odor and delayed healing.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear.
Cleanse wound and prepare and protect peri-wound skin	Cleanse with saline or wound cleanser and pat dry.

Pressure injuries: Stage 4 | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Apply primary and secondary dressing as needed	**Minimal drainage:** Consider using a dressing that promotes moist wound healing, such as: Xeroform, hydrogel, thin silicone foam, or MEDIHONEY® Hydrogel, Gel or Paste. If a secondary dressing is necessary, consider bordered gauze, composite dressing, or non-adherent dressing secured with rolled gauze. **Moderate to heavy amount of drainage:** Consider a dressing which absorbs moisture. Loosely fill any depth with calcium alginate, gelling fiber, or MEDIHONEY® Alginate. If a secondary dressing is necessary, consider a silicone bordered foam or specialty absorptive dressing. If needed, secure with rolled gauze or stretch net.
Considerations	If contamination is suspected, consider using antimicrobial treatments. If wound healing is slow or stalled, consider adding collagen when the wound base is free of necrotic tissue. Assess for appropriateness of debridement and refer to prescribing authority according to agency or facility policy.

Unstageable pressure injury

Unstageable pressure injury: Obscured full-thickness skin and tissue loss

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.[11]

Unstageable pressure injury | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, tissue type, drainage amount and character, peri-wound skin. Assess for signs and symptoms of infection to include pain, erythema, edema, heat/warmth, increased and/or purulent drainage, foul odor and delayed healing.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear.
Cleanse wound and prepare and protect peri-wound skin	Cleanse with saline or wound cleanser and pat dry.

Unstageable pressure injury | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Apply primary and secondary dressing as needed	**Minimal drainage:** Consider using a dressing that promotes autolytic debridement, such as: hydrogel, hydrocolloid or MEDIHONEY® Gel or Paste. If a secondary dressing is necessary, consider bordered gauze, a composite dressing or a thin silicone foam. If needed, secure with rolled gauze or stretch net. **Moderate to heavy drainage:** If autolytic debridement is desired, cover with MEDIHONEY® Gel or consider a dressing which absorbs moisture. Loosely fill any depth with calcium alginate, gelling fiber, or MEDIHONEY® Alginate. If a secondary dressing is necessary, consider a silicone bordered foam or specialty absorptive dressing. If needed, secure with rolled gauze or stretch net.
Considerations	If contamination is suspected, consider using antimicrobial treatments. If wound healing is slow or stalled, consider adding collagen when the wound base is free of necrotic tissue. Assess for appropriateness of debridement and refer to prescribing authority according to agency or facility policy. Debridement may be contraindicated in patients with poor circulation.

Deep tissue pressure injury

Deep tissue pressure injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin.

This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.[11]

Deep tissue pressure injury | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, color, blood blister, pain, firm, mushy/boggy, warm or cool.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear.
Cleanse wound and prepare and protect peri-wound skin	Gently cleanse during routine bathing and pat dry. Typically no dressing is required. Options may include no-sting skin barrier, transparent film, or multi-layered, bordered silicone foam.
Considerations	Difficult to detect in those with dark skin tones. Evolution may include a blister over a dark wound bed, and the wound may further evolve and become covered by eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Arterial ulcer

Caused by occlusion of arterial blood flow primarily due to PAD (Peripheral Arterial Disease). They are typically located on extremities exposed to pressure, friction, or trauma. The most common areas include the toes, heels, and ankle malleoli.

Characteristics may include circumscribed, punched-out appearance with gangrene or necrosis, pale deep wound bed, blanched or dusky peri-wound skin, minimal drainage, cellulitis and extreme pain in those without neuropathy.

Arterial Ulcer | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, tissue type, drainage amount and character, peri-wound skin. Assess for signs and symptoms of infection to include pain, erythema, edema, heat/warmth, increased and/or purulent drainage, foul odor and delayed healing.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear. Offloading pressure to wound, ABI (ankle brachial index)/arterial blood flow, glucose control.
Cleanse wound	Cleanse with saline or wound cleanser and pat dry.

Arterial Ulcer | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Apply primary and secondary dressing as needed	**Minimal drainage:** Consider using a dressing that promotes moist wound healing, such as: Xeroform, hydrogel, hydrophilic wound dressing, thin silicone foam, or MEDIHONEY® Hydrogel, Gel or Paste. If a secondary dressing is necessary, consider bordered gauze, composite dressing, or non-adherent dressing secured with rolled gauze. **Moderate to heavy amount of drainage:** Consider a dressing which absorbs moisture. Loosely fill any depth with calcium alginate, gelling fiber, or MEDIHONEY® Alginate. If a secondary dressing is necessary, consider a silicone bordered foam or specialty absorptive dressing. If needed, secure with rolled gauze or stretch net.
Considerations	If contamination is suspected, consider using antimicrobial treatments. If wound healing is slow or stalled, consider adding collagen when the wound base is free of necrotic tissue. Assess for appropriateness of debridement and refer to prescribing authority according to agency or facility policy. Debridement may be contraindicated in wounds with dry, stable eschar compromised by poor circulation.

Neuropathic/diabetic ulcers

Neuropathic ulcers form as a result of peripheral neuropathy, typically in diabetic patients. Local paresthesias, or lack of sensation, over pressure points on the foot leads to extended microtrauma, breakdown of overlying tissue, and eventual ulceration. Neuropathic ulcers are typically located on the plantar aspect of the foot, over the metatarsal heads and under the heel and the toes.

Characteristics may include absent or diminished sensation, foot deformities, Charcot Foot, varying depth of wound bed, and low to moderate drainage. Underlying osteomyelitis is a risk in this patient population and should be evaluated.

Offloading, debridement and infection management are the mainstays of treatment.

Neuropathic/diabetic ulcers | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, tissue type, drainage amount and character, peri-wound skin. Assess for signs and symptoms of infection to include pain, erythema, edema, heat/warmth, increased and/or purulent drainage, foul odor, elevated blood sugars and delayed healing.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear. Offloading pressure to wound, ABI (ankle brachial index)/arterial blood flow, glucose control. Assess for appropriateness of debridement and refer to physician or nurse practitioner as needed. Debridement may be contraindicated in wounds with dry stable eschar compromised by poor circulation.
Cleanse wound	Cleanse with saline or wound cleanser and pat dry.

Neuropathic/diabetic ulcers | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Apply primary and secondary dressing as needed	**Minimal drainage:** Consider using a dressing that promotes moist wound healing, such as: Xeroform, hydrogel, hydrophilic wound dressing, thin silicone foam, or MEDIHONEY® Hydrogel, Gel or Paste. If a secondary dressing is necessary, consider bordered gauze, composite dressing, or non-adherent dressing secured with rolled gauze. **Moderate to heavy amount of drainage:** Consider a dressing which absorbs moisture. Loosely fill any depth with calcium alginate, gelling fiber, or MEDIHONEY® Alginate. If a secondary dressing is necessary, consider a silicone bordered foam or specialty absorptive dressing. If needed, secure with rolled gauze or stretch net.
Considerations	If contamination is suspected, consider using antimicrobial treatments. If wound healing is slow or stalled, consider adding collagen when the wound base is free of necrotic tissue.

Venous leg ulcer

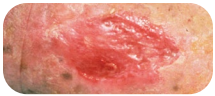
A venous ulcer is a shallow wound that occurs due to venous insufficiency and increased tissue pressure in the lower extremities, resulting in edema.

Venous ulcers usually form on the sides of the lower leg, above the ankle and below the knee in the gaiter area. They are characterized by irregular poorly defined margins, ruddy granulation tissue, adherent slough, moderate to heavy drainage and moderate pain.

Gradient compression with local wound care, focusing on infection prevention and exudate management, is the mainstay of treatment.

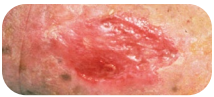
ABI (Ankle-Brachial Index) may be used to assess arterial supply to the lower extremities prior to initiating any compression.

Venous leg ulcer | *continued*



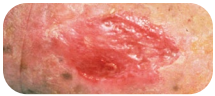
STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, tissue type, drainage amount and character, peri-wound skin. Assess for signs and symptoms of infection to include pain, erythema, edema, heat/warmth, increased and/or purulent drainage, foul odor and delayed healing.
Assess and address contributing factors	Ankle brachial index or ABI is recommended prior to initiating compression therapy. Trained clinicians can use the ABI results to assess a patient's arterial flow and determine the appropriate level of compression.
Cleanse wound and prepare and protect peri-wound skin	Cleanse with saline or wound cleanser and pat dry.

Venous Leg Ulcer | *continued*



STEP	ASSESSMENT AND SUGGESTED ACTIONS
Apply primary and secondary dressing as needed	**Minimal drainage:** Consider using a dressing that promotes moist wound healing, such as: Xeroform, hydrogel, hydrophilic wound dressing, thin silicone foam, or MEDIHONEY® Hydrogel, Gel or Paste. If a secondary dressing is necessary, consider bordered gauze, composite dressing, or non-adherent dressing secured with rolled gauze. **Moderate to heavy amount of drainage:** Consider a dressing which absorbs moisture. Loosely fill any depth with calcium alginate, gelling fiber, or MEDIHONEY® Alginate. If a secondary dressing is necessary, consider a silicone foam or specialty absorptive dressing. If needed, secure with rolled gauze or stretch net.

Venous leg ulcer | *continued*



STEP	ASSESSMENT AND SUGGESTED ACTIONS
Considerations	Compression therapy is the mainstay treatment for chronic venous insufficiency. It is essential to assess arterial flow prior to implementing compression therapy; refer for vascular consult as needed. Unna boots and multi-layer compression dressings are commonly used to treat venous leg ulcers. Unna boots are designed for use on ambulatory patients or residents.

Traumatic wounds

Skin and tissue can be injured by one of the many forms of trauma, including, but not limited to:

- Abrasions
- Avulsions
- Contusions
- Crush wounds
- Cuts
- Lacerations
- Missile wounds
- Punctures

Treatment of these wounds depends on the type and severity of the trauma. Skin tears are a wound caused by trauma.

Skin tear

A skin tear is a wound caused by shear, friction and/or blunt force resulting in separation of skin layers. Skin tears are acute wounds, which have a high probability of becoming complex chronic wounds, if not properly managed. They can occur on any part of the body, but are particularly common in populations with fragile skin, such as the elderly, chronic or critically ill patients, neonates and pediatric patients.[12]

The International Skin Tear Advisory Panel (ISTAP) skin tear classification is:

Type 1: No skin loss; linear or flap tear that can be repositioned to cover the wound bed.

Type 2: Partial skin loss; partial flap loss that cannot be repositioned to cover the wound bed.

Type 3: Total flap loss; total flap loss exposing entire wound bed.

Skin tear | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Assess wound	Location, size, tissue type, drainage amount and character, peri-wound skin. Assess for signs and symptoms of infection to include pain, erythema, edema, heat/warmth, increased and/or purulent drainage, foul odor and delayed healing.
Assess and address contributing factors	Pressure, sensory perception, moisture, incontinence, mobility, nutrition, friction and shear. Evaluate trauma, medications, vitamin deficiencies, and thin, fragile, dry skin; implement appropriate preventative interventions.
Cleanse wound and prepare and protect peri-wound skin	Cleanse with saline or wound cleanser and pat dry.

Skin tear | *continued*

STEP	ASSESSMENT AND SUGGESTED ACTIONS
Apply primary and secondary dressing as needed	If skin flap is present and viable, gently approximate/realign if possible (do not remove flap unless necrotic). Select dressing based on wound characteristics. **If dry or scant drainage:** Consider using a dressing that minimizes additional trauma to the tissue and promotes moist wound healing, such as: Xeroform, hydrogel, hydrogel sheet, silicone contact layer or thin silicone bordered foam. If a secondary dressing is necessary, consider securement with rolled gauze or stretch net. **If moderate to heavy amount of drainage:** Consider a dressing which absorbs moisture such as a silicone bordered foam or specialty absorptive dressing. If needed, secure with rolled gauze or stretch net.
Considerations	Avoid wound dressings which may adhere to the fragile skin flap and potentially cause more damage upon removal, like dry gauze, transparent film, hydrocolloids, etc. According to ISTAP, wound closure strips are no longer a preferred treatment for skin tears.

Burns

Superficial – first degree

Damage limited to the epidermis, characterized by erythema, hyperemia, tenderness and pain. A superficial burn is the least severe. It reddens the skin and can be painful but is not life-threatening. Common causes: sunburn, hot liquids.[7]

Superficial partial thickness – second degree

Damage extends through the epidermis downward into the papillary or superficial into the dermal layer; characterized by large blisters, edema, pain, and wet weeping, shiny surface can lead to permanent scarring, and may need to be grafted. Common causes: hot liquids, flash injury, flame injury, scalding liquids.[7]

Deep partial thickness – second degree

Most skin is destroyed except for a small amount of remaining dermis. The wound looks white or charred, indicating dead tissue. Blood flow is compromised and a layer of dead dermis or eschar adheres to the wound surface. Pain is much less as the nerves are actually destroyed by the heat. The presence of sensation to touch usually indicates the burn is a deep partial injury.[7]

Burns | *continued*

Full thickness – third degree

Extends through the epidermis and dermis and into the subcutaneous tissue. Subdermal burn damages muscle, bone and interstitial tissue. Characterized by deep-red, black or white appearance; edema, painless nerve ending damage; and exposed subcutaneous fat layer. Common causes: prolonged flame, steam or scalding liquids, chemical or electrical injury.[7]

Treatment

Burn patients need to seek specialized care. Treatment will vary depending on the extent of tissue damage, source of the burn, and the total surface area.

Irritant Contact Dermatitis (ICD)

Irritant contact dermatitis (ICD) is the inflammation and erosion of the skin which is caused by prolonged exposure to various sources of moisture. ICD is further defined by the source of the moisture, including urine, stool, saliva, effluent from an ostomy or fistula and other body fluids.

This is sometimes called moisture-associated skin damage. It may be misdiagnosed as a pressure injury when located on the buttocks. Considerations for treatment include managing the excessive moisture and protecting the skin[13].

Surgical wounds

Surgical wounds are caused when incisions are made through the skin and/or soft tissues.

These wounds may close via primary, secondary or tertiary intention.

In primary intention the wound edges are reapproximated using sutures, staples, adhesive strips, or surgical glue.

In secondary intention the wound is not surgically closed, but is left open to heal via granulation and epithelialization. This method of healing may be employed when contamination is a concern.

Tertiary intention is also known as delayed primary closure. In this method, the wound is intentionally left open and later closed in a fashion similar to primary intention.

Surgical Site Infections (SSI)

Signs and symptoms of SSI may include:

- Erythema around the incision site
- Purulence from the incision site
- Delayed healing
- Fever
- Increased pain
- Tenderness
- Warmth
- Swelling
- Induration
- Dehiscence

Lymphedema

Reference footnote[14]

Lymphedema is chronic swelling caused by the accumulation of protein rich fluid that is typically drained through the body's lymphatic system. It can be primary due to congenital malformations or secondary from injury or obstruction of the lymphatic system. Swelling can occur anywhere in the body but most commonly in the arms, legs, genitals, face, breast, and neck.

Lymphedema may lead to skin changes such as thickening and hardening, infections, weeping, and open wounds.

Lymphedema is a progressive disease that is lifelong and often debilitating. Proper lymphedema treatment may include decongestive lymphedema therapy, manual lymph drainage, compression, skin care, exercise, weight management and local wound care.

Palliative Wounds

Reference footnote[15]

Even if wound healing is not a realistic expectation at the end of life, wound care should still be offered to help with troublesome symptoms. The treatment of pain, exudate management, odor control, infection, and bleeding can enhance comfort and improve the quality of life. This is the focus of palliative wound care.

Fungating/Malignant Wound

Malignant or fungating wounds occur when cancerous cells invade the epithelium, infiltrate the supporting blood and lymph vessels, and penetrate the epidermis[16]. These wounds may have friable tissue, excessive and/or malodorous exudate, can be difficult to dress, and may continue to grow despite appropriate treatment.

Include the utilization of products to decrease odor, promote hemostasis, absorb exudate, and minimize tissue trauma when removed.

Kennedy Terminal Ulcer(KTU)/SCALE/Skin Failure at End of Life

The skin is largest body organ by surface area. During the dying process blood may be shunted away from the skin making it more vulnerable to skin breakdown. A KTU typically starts on the sacrum as a dark, purplish discoloration. It may quickly deteriorate in size and depth, as end of life approaches. Palliative wound treatments should be utilized as previously mentioned.[17,18]

McKesson product portfolio

Product selection guides

Connecting the right product to the right application is critical to achieving goals with advanced skin and wound assessment and treatment. McKesson offers a comprehensive line of products, both McKesson Brands and national brands, to help meet your advanced skin and wound care needs.

Included in this guide are examples of our comprehensive product portfolio for advanced wound care prevention and treatment.

For more information, visit ***mms.mckesson.com/resources/wound-care*** or contact the McKesson Clinical Resource Team at **877.611.0081**

Our products are available in various units of measure – from single products to cases. Contact your McKesson Account Manager or check out ***mms.mckesson.com*** to order today.

Wound Prevention

Wound Prevention

Advanced skin care

Advanced skin care

Maintaining skin integrity is the first step in preventing wounds. High quality skin care products and equipment which redistributes pressure are two interventions used to protect tissue from damage.

ADVANCED SKIN CARE PRODUCTS

Advanced skin care products work to prevent, cleanse, moisturize, protect and treat at-risk skin.

THERA®

Thera is a specially formulated group of products that help address skin issues and protect and treat skin irritation.

INFUSED WITH SAFFLEX™ VITAMIN COMPOUND

Each product in the THERA® Advanced Skin Care line is enriched with an all-in-one proprietary blend of vitamins and nourishing ingredients. It contains:

- Vitamin E acetate
- Vitamin C
- Vitamin B3
- Vitamin B5
- Vitamin B6
- Safflower seed oil
- Hyaluronic acid
- Lavender-ylang fragrance
- Bisabolol (an extract of chamomile)
- Ginger root extract

Thera®

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Adhesive removers

Adhesive removers are solvents formulated to dissolve adhesives and assist in removing dressings, skin protectors, tapes and any product that adheres to the skin.

Product description	MFR#
3M™	
Remover lotion, 4 oz. 20/BX	8610
MCKESSON BRANDS	
Adhesive remover wipes, 50/BX	176-5729
SMITH & NEPHEW	
UNI-SOLVE™ adhesive remover wipes, 4 oz. 50/BX	402300

Antifungals

Antifungals are medicated powders, creams, lotions or ointments used topically to treat fungus and yeast.

Product description	MFR#
MCKESSON BRANDS	
Thera® Antifungal Body Powder, 3 oz.	53-AFP3
Thera® Antifungal Body Cream, 4 oz.	53-AFC4
SMITH & NEPHEW	
SECURA™ Antifungal Cream, 3 1/4 oz.	59432900
SECURA™ Antifungal Greaseless, 2 oz.	59432800

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Moisture barriers

Moisture barriers are creams, ointments or pastes that protect the skin from damage assoicated with incontinence, perspiration or wound drainage. These products protect the skin, create proper moisture balance and prevent transepidermal water loss.

Product description	MFR#
3M™	
Cavilon™ Durable Barrier Cream, 2 gram Sachet	3353
Cavilon™ Durable Barrier Cream, 1 oz.	3354
Cavilon™ Durable Barrier Cream, 3 1/4 oz.	3355
MCKESSON BRANDS	
Thera® Moisturizing Body Shield, 4 gram Packet	53-MS4G
Thera® Moisturizing Body Shield, 4 oz.	53-MS4
Thera® Dimethicone Body Shield, 4 oz.	53-DS4
Thera® Calazinc Body Shield, 4 gram Packet	53-CZ4G
Thera® Calazinc Body Shield, 4 oz.	53-CZ4
Thera® Silicone Skin Guard, 4 oz.	53-SSG4

Moisture barriers | *continued*

Product description	MFR#
SMITH & NEPHEW	
SECURA™ Protective Cream, 1.75 oz.	59431100
SECURA™ Protective Cream, 2.75 oz.	59431200
SECURA™ Extra Protective Cream, 3.25 oz.	59432400
SECURA™ Dimethicone Protectant, 4 oz.	59432200
SECURA™ Dimethicone Protectant, 3.5 gram Packet	59435000

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Moisture wicking fabric with antimicrobial silver

Moisture wicking fabric is a soft 100% polyester fabric with ionic silver that wicks and translocates moisture, keeping the skin dry in skin folds and other skin-on-skin contact areas.[19, 20]

Product description	MFR#
COLOPLAST	
InterDry®, 10" x 36" Packet	7912
InterDry®, 10" x 144" Roll	7910
MCKESSON BRANDS	
Moisture Wicking Fabric, 10" x 36" Sheet	16-1036S
Moisture Wicking Fabric, 10" x 144" Roll	16-10144R

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Moisturizers

Moisturizers help maintain skin integrity by hydrating and soothing dry or irritated skin.

Product description	MFR#
3M™	
Cavilon™ 3-in-1 Incontinence Care Lotion, 8 oz.	3383
Cavilon™ Extra Dry Skin Cream, 4 oz.	3386
MCKESSON BRANDS	
Thera® Moisturizing Body Cream, 4 oz.	53-CRM4
Thera® Moisturizing Body Cream, 32 oz. Pump Bottle	53-CRM32
SMITH & NEPHEW	
SECURA™ Moisturizing Cream, 3 oz.	59431900
SECURA™ Moisturizing Cream, 6.5 oz.	5943200

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

No-sting liquid barrier film

Liquid barrier films are formulations designed to protect vulnerable areas from the effects of 1) mechanical or chemical injury and 2) excessive moisture due to incontinence, perspiration or wound drainage. They form a transparent film on the skin.

Product description	MFR#
3M™	
Cavilon™ No Sting Barrier Film, 1 mL Wipe	3344
Cavilon™ No Sting Barrier Film, 28 mL Bottle	3346
Cavilon™ No Sting Barrier Film, 1 mL Wand	3343
Cavilon™ No Sting Barrier Film, 3 mL Wand	3345
Cavilon™ Advanced, 0.7 mL Wand	5051
Cavilon™ Advanced, 2.7 mL Wand	5050
MCKESSON BRANDS	
No-Sting Skin Barrier Film, Wipe	176-5728
SMITH & NEPHEW	
NO-STING SKIN-PREP™, 1 oz. Spray	66800709
NO-STING SKIN-PREP™, 1 mL Wipe	59420600

Rinse-free skin cleansers

Skin cleansers are the first step in the process of cleansing, moisturizing and protecting the skin. Rinse-free formulas clean without water and are pH balanced for optimal skin health.

Product description	MFR#
3M™	
Cavilon™ No-Rinse Skin Cleanser, 8 oz.	3380
MCKESSON BRANDS	
Rinse-Free Perineal Wash, 8 oz.	53-28133
Perineal and Skin Cleanser Rinse-Free, 8 oz.	53-28013-8
Foaming Cleanser Rinse-Free, 9 oz.	53-22952-9
Thera® Foaming Body Cleanser, 5 oz. Pump	53-FC5
Thera® Foaming Body Cleanser, 9 oz. Pump	53-FC9
Thera® Moisturizing Body Cleanser, 8 oz.	53-MC8
Thera® Antimicrobial Body Cleanser, 4 oz.	53-AC4
Thera® Antimicrobial Body Cleanser, 8 oz.	53-AC8
SMITH & NEPHEW	
SECURA™ Total Body Foam Cleanser, 4.5 oz.	59430200
SECURA™ Total Body Foam Cleanser, 8.5 oz.	59430300

Wound Prevention

Equipment

Equipment – Heel protectors and positioners

Pressure, friction, and shearing forces can damage tissue and contribute to pressure injury formation. Clinicians should use validated tools such as Norton Scale or Braden Risk Assessment Scale to assess a patient's risk of pressure injury. Clinicians should use the patient's risk assessment score and their agency guidelines to identify appropriate equipment interventions. Pressure redistribution equipment may include wheelchair cushions, support surfaces, positioners, and offloading devices. Pressure redistribution equipment is only one part of a comprehensive pressure injury prevention program.[11]

Product description	MFR#
MCKESSON BRANDS	
Heel Protection Pad	136-28656
Heel Protector	16-7305
Positioner Wedge	136-84587
MOLNLYCKE	
Z-Flex™ Fluidized Heel Boot	1400122
Z-Flo™ Fluidized Positioner 12" W x 20" D	1401007

Please visit *https://mck.ink/dme-products-24* for a full offering.

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Equipment – Support surfaces

Product description	MFR#
MCKESSON BRANDS	
Therapeutic Mattress, 35" x 80" x 6"	GS8035-29
Alternating Pressure/Low Air Loss, 80" x 36" x 8"	146-14027
Air Therapy APM Alternating pressure mattress	1128

Product description	MFR#
DRIVE MEDICAL	
Gravity 7 Pressure Redistribution Mattress, 36" x 80" x 6"	15770
Gravity 8 Deluxe Pressure Restribution Mattress, 36" x 80" x 6"	15870
Gravity 9 Pressure Redistribution Mattress, 36" x 80" x 6"	15970
Med-Aire® Assure Alternating Pressure/Low Air Loss, 35.5" x 80" x 8"	14530
Med-Aire® Plus Alternating Pressure/Low Air Loss, 36" x 80" x 8"	14029
Med-Aire® Edge Alternating Pressure/Low Air Loss , 35" x 80" x 8"	14360-P

Equipment – Wheelchair cushions

Product description	MFR#
MCKESSON BRANDS	
Premium Wheelchair Molded Foam, Seat Cushion, 18"W x 16"D x 3"H	170-76002SP
Premium Wheelchair Gel, Seat Cushion with Molded Foam, 18"W x 16"D x 3"H	170-77002

For a full listing of our offerings, including bariatric options, visit https://mck.ink/dme-products-24

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Equipment – Wheelchair cushions | *continued*

Product description	MFR#
DRIVE MEDICAL	
Gel-U-Seat™ Lite General Use, 18"W x 16"D x 2"H	8040-2
Gel-U-Seat™ Lite General Use, 20"W x 16"D x 3"H	8046-3
Titanium Skin Protection and Positioning Gel/Foam, 16"W x 16"D x 3 ½"H	FPT-1
Balanced Aire Adjustable Skin Protection, 16"W x 16"D x 4"H	8047-16

For a full listing of our offerings, including bariatric options, visit https://mck.ink/dme-products-24

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Treatment

Bordered gauze

Bordered gauze offers a one-step application and is an alternative to gauze and tape. It is designed with a non-adherent central gauze pad to allow for absorption of light to moderate drainage.

Product description	MFR#
3M™	
Medipore™ +Pad, 3 1/2" x 4"	3566
Medipore™ +Pad, 4" x 4"	3568
Medipore™ +Pad, 3 1/2" x 6"	3569
Medipore™ +Pad, 1 3/4" x 6"	3570
Medipore™ +Pad, 1 3/4" x 8"	3571
Medipore™ +Pad, 1 3/4" x 11 3/4"	3573
MCKESSON BRANDS	
Island Dressing, 2" x 2"	16-89022
Island Dressing, 4" x 4"	16-89044
Island Dressing, 4" x 8"	16-89048
Island Dressing, 4" x 10"	16-89041
Island Dressing, 4" x 14"	16-89042
Island Dressing, 6" x 6"	16-89066

Bordered gauze | *continued*

Product description	MFR#
MOLNLYCKE	
Mepore®, 3 3/5" x 4"	670900
Mepore®, 3 3/5" x 6"	671000
Mepore®, 3 3/5" x 8"	671100
Mepore®, 3 3/5" x 10"	671299
Mepore®, 3 3/5" x 12"	671300
SMITH & NEPHEW	
COVRSITE™ Adhesive, 4" x 4"	59714100
COVRSITE™ Adhesive, 6" x 6"	59714400

Calcium alginate and gelling fiber dressing

Calcium alginates and gelling fiber dressings are primary dressings that cover or fill wounds with moderate to heavy drainage.

Without antimicrobial silver

Product description	MFR#
3M™	
Kerracel™ Gelling Fiber, 2" x 2"	CWL1032
Kerracel™ Gelling Fiber, 4" x 5"	CWL1033
Kerracel™ Gelling Fiber, 6" x 6"	CWL1034
Kerracel™ Gelling Fiber, 1" x 18" Ribbon	CWL1035
MCKESSON BRANDS	
Calcium Alginate, 2" x 2"	3561
Calcium Alginate, 4" x 4 3/4"	3562
Calcium Alginate, 3/4" x 12" Rope	3564
Gelling Fiber, 2" x 2"	87200
Gelling Fiber, 4" x 4 3/4"	87400
Gelling Fiber, 6" x 6"	87600
Gelling Fiber, 3/4" X 12" Rope	87180

Calcium alginate and gelling fiber dressing
| *continued*

Without antimicrobial silver

Product description	MFR#
MOLNLYCKE	
Melgisorb® Plus Calcium Alginate, 2" x 2"	252000
Melgisorb® Plus Calcium Alginate, 4" x 4"	252200
Melgisorb® Plus Calcium Alginate, 1 1/4" x 17 3/4" Rope	253500
Exufiber®, 2" x 2"	709900
Exufiber®, 4" x 5"	709901
Exufiber®, 6" x 6"	709903
Exufiber®, 0.8" x 17.7" Rope	709909
SMITH & NEPHEW	
ALGISITE™ M Calcium Alginate, 2" x 2"	59480100
ALGISITE™ M Calcium Alginate, 4" x 4"	59480200
ALGISITE™ M Calcium Alginate, 3/4" x 12" Rope	59480400
DURAFIBER Gelling Fiber, 2" x 2"	66800559
DURAFIBER Gelling Fiber, 4"x 4"	66800560
DURAFIBER Gelling Fiber, 4" x 4 3/4"	66800551
DURAFIBER Gelling Fiber, 6"x6"	66800561
DURAFIBER Gelling Fiber, 3/4" x 18" Rope	66800563

Calcium alginate and gelling fiber dressing
| continued

With anitimicrobial silver

Product description	MFR#
3M™	
SILVERCEL™ NON-ADHERENT Antimicrobial Dressing, 4-1/4" x 4-1/4"	900404
SILVERCEL™ NON-ADHERENT Antimicrobial Dressing, 1" x 12"	900112
MCKESSON BRANDS	
Calcium Alginate with Silver, 2" x 2"	3557
Calcium Alginate with Silver, 4" x 4 3/4"	3558
Calcium Alginate with Silver, 3/4" x 12" Rope	3560
Gelling Fiber with Silver, 2" x 2"	177200
Gelling Fiber with Silver, 4" x 4 3/4"	177400
Gelling Fiber with Silver, 6" x 6"	177600
Gelling Fiber with Silver, 3/4" x 18" Rope	177180

Calcium alginate and gelling fiber dressing
| *continued*

With antimicrobial silver

Product description	MFR#
MOLNLYCKE	
Melgisorb® Ag Calcium Alginate, 2" x 2"	255050
Melgisorb® Ag Calcium Alginate, 4" x 4"	255100
Melgisorb® Ag Calcium Alginate, 6" x 6"	255150
Melgisorb® Ag Calcium Alginate, 1 2/10" x 18" Rope	255600
Exufiber® Ag Gelling Fiber, 2" x 2"	603421
Exufiber® Ag Gelling Fiber, 4" x 4"	603425
Exufiber® Ag Gelling Fiber, 6" x 6"	603423
Exufiber® Ag Gelling Fiber, 4/5" x 17 2/3" Rope	603420
SMITH & NEPHEW	
DURAFIBER Ag Gelling Fiber, 2" x 2"	66800570
DURAFIBER Ag Gelling Fiber, 4" x 4"	66801174
DURAFIBER Ag Gelling Fiber, 6" x 6"	66800572
DURAFIBER Ag Gelling Fiber, 3/4" x 18" Rope	66800574

Collagen

Collagen wound dressings are derived from a variety of animal sources. They encourage deposition and organization of newly formed collagen fibers and granulation tissue in the wound bed, stimulating new tissue development.

Without antimicrobial silver

Product description	MFR#
3M™	
PROMOGRAN™ Matrix, 4-17/50 sq. in.	PG004
PROMOGRAN™ Matrix, 19-1/10 sq. in.	PG019
MCKESSON BRANDS	
Collagen, 2" x 2"	16-1850
Collagen, 4" x 4"	16-1852
Collagen Powder, 1g	1800P
SMITH & NEPHEW	
BIOSTEP™, 2" x 2"	66800124
BIOSTEP™, 4" x 4"	66800125

Collagen | *continued*

With antimicrobial silver

Product description	MFR#
3M™	
PROMOGRAN™ PRISMA Matrix, 4-17/50 sq. in.	MA028
PROMOGRAN™ PRISMA Matrix, 19-1/10 sq. in.	MA123
PROMOGRAN™ PRISMA Matrix, 19-1/10 sq. in. Rope	MA032
MCKESSON	
Collagen with Silver, 2" x 2"	16-1860
Collagen with Silver, 4" x 4"	16-1862
SMITH & NEPHEW	
BIOSTEP™ Ag, 2" x 2"	66800126
BIOSTEP™ Ag, 4" x 4"	66800122

Composite dressing

Composite dressings are soft, flexible and comfortable for enhanced wearability. They have a water-resistant film layer which acts as an effective barrier to outside contamination and permits showering.

Product description	MFR#
3M™	
TEGADERM™ +PAD, 1-3/4" x 2 3/8"	3587
TEGADERM™ +PAD, 1-3/4" x 4"	3589
TEGADERM™ +PAD, 1-3/4" x 6"	3590
TEGADERM™ +PAD, 4" x 4"	3588
TEGADERM™ +PAD, 3-1/2" x 10"	3591
TEGADERM™ +PAD, 3-1/2" x 13-3/4"	3593
MCKESSON	
Barrier Island Dressings, 4" x 4"	16-89144
Barrier Island Dressings, 6" x 6"	16-89166

Composite dressing | *continued*

Product description	MFR#
MOLNLYCKE	
Alldress®, 4" x 4"	265329
Alldress®, 6" x 6"	265349
Mepore® Pro, 3-3/5" x 4"	670990
Mepore® Pro, 3-3/5" x 6"	671090
Mepore® Pro, 3-3/5" x 8"	671190
Mepore® Pro, 3-3/5" x 10"	671290
Mepore® Pro, 3-3/5" x 12"	671390
Mepore® Pro, 3 3/5" x 14"	671400
SMITH & NEPHEW	
COVRSITE™ PLUS, 4" x 4"	59715000
COVRSITE™ PLUS, 6" x 6"	59715100

Compression – multi-layer bandages

Multi-layer compression bandage systems are used in venous disease and edema management. These systems provide graduated, sustained compression.

Product description	MFR#
3M™	
Coban™ 2 Two-Layer Compression System with Stocking, 2-9/10 yd x 4" /4" x 5-1/10 yd	2094N
Coban™ 2 Two-Layer Compression System, 4" x 3-4/5 yd /4" x 6-3/10 yd	2094XL
Coban™ Lite 2 Two-Layer Compression System, 6" x 3-4/5 yd /6" x 4-9/10 yd	2794N
MCKESSON BRANDS	
Compression Bandage System, 2 Layer	2006
SMITH & NEPHEW	
PROFORE™ Lite Compression Bandaging System, 3 layer	66000771
PROFORE™ Compression Bandaging System, 4 layer	66020016

Compression – tubular support bandage

Tubular elastic bandages provide even compression and support.

Product description	MFR#
MCKESSON BRANDS	
Elastic Tubular Bandage, Lg Arm/Med Ankle/Sm Knee	182-13113D
Elastic Tubular Bandage, Lg Ankle/Med Knee/Sm Thigh	182-13114E
Elastic Tubular Bandage, Lg Knee/Med Thigh	182-13115F
MOLNLYCKE	
Tubigrip® Lg Arm/Med Ankle/Sm Knee	1437
Tubigrip® Knee/Sm Thigh	1434
Tubigrip® Lg Knee/Med Thigh	1438

Compression – tubular net retainer dressing

Tubular net retainer dressings are secondary dressings which can keep bandages and devices securely in place without adhesives.

Product description	MFR#
MCKESSON BRANDS	
Tubular Elastic Retainer Net, Size 4	MSVP114704
Tubular Elastic Retainer Net, Size 5	MSVP114705
Tubular Elastic Retainer Net, Size 8	MSVP114708

Compression – Unna boot

Unna boots are non-hardening zinc impregnated bandages used for compression therapy. They are available with or without calamine.

Product description	MFR#
MCKESSON BRANDS	
Unna Boot, with Zinc Oxide, 3"	2066S
Unna Boot, with Zinc Oxide, 4"	2067S
Unna Boot, with Zinc Oxide and Calamine, 3"	2068S
Unna Boot, with Zinc Oxide and Calamine, 4"	2069S
SMITH & NEPHEW	
VISCOPASTE™ PB7 Zinc Paste Bandage, 3"	4956

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Contact layer – silicone

Silicone contact layers are dressings with a porous mesh design that allows exudate to pass into a secondary dressing. The gentle silicone adhesive may help reduce pain and trauma upon removal while extending wear time.

Without antimicrobial silver

Product description	MFR#
3M™	
ADAPTIC™ Touch Silicone Contact Layer, 2" x 3"	TCH501
ADAPTIC™ Touch Silicone Contact Layer, 3" x 4-1/4"	TCH502
ADAPTIC™ Touch Silicone Contact Layer, 5" x 6"	TCH503
MCKESSON	
Silicone Contact Layer, 3" x 4"	4816
Silicone Contact Layer, 4" x 7-2/10"	4817
MOLNLYCKE	
Mepitel® Silicone Contact Layer, 2" x 3"	290599
Mepitel® Silicone Contact Layer, 3" x 4"	290799
Mepitel® Silicone Contact Layer, 4" x 7"	291099
Mepitel® One Silicone Contact Layer, 2" x 3"	289100
Mepitel® One Silicone Contact Layer, 3" x 4"	289300
Mepitel® One Silicone Contact Layer, 4" x 7"	289500

Contact layer-silicone | *continued*

With antimicrobial silver

Product description	MFR#
MOLNLYCKE	
Mepitel® Ag Silicone Contact Layer, 2" x 3"	390590
Mepitel® Ag Silicone Contact Layer, 3" x 4"	390790
Mepitel® Ag Silicone Contact Layer, 4" x 5"	390090
Mepitel® Ag Silicone Contact Layer, 2" x 7"	391090

Foam

Foam dressings are used to absorb exudate from a draining wound. They can be bordered or non-bordered, with or without silver, and come in a variety of shapes. Some bordered foams have been shown to reduce friction and shear. Consider these dressings to help protect bony prominences or areas at risk for skin breakdown due to pressure.

Non-bordered foam

Product description	MFR#
3M™	
Tegaderm™ Foam, 2" x 2"	90600
Tegaderm™ Foam, 4" x 4"	90601
Tegaderm™ Foam, Silicone Face 4" x 4-1/2"	90631
Tegaderm™ Foam, Silicone Face, 6" x 6"	90632
MCKESSON	
Foam-Film Backed, 4" x 4"	16-4737
Foam-Film Backed, 6" x 6"	16-4738
Hydrocellular Foam, 4" x 4"	16-4739
Foam, Silicone Face, 3" x 3"	4862
Foam, Silicone Face, 4" x 4"	4863
Foam, Silicone Face, 6" x 6"	4864
Light Foam, Silicone Face, 3" x 3"	4892
Light Foam, Silicone Face, 4" x 4"	4893
Light Foam, Silicone Face, 6" x 6"	4894

Clinical information: **877.611.0081** | To order: **mms.mckesson.com**

Non-bordered foam

Product description	MFR#
MOLNLYCKE	
Mepilex®, Silicone Face, 4" x 4"	294199
Mepilex®, Silicone Face, 4" x 5"	294090
Mepilex®, Silicone Face, 6" x 6"	294399
Mepilex® Heel, Silicone Face, 5" x 8"	288100
Mepilex® Lite, Silicone Face, 4" x 4"	284190
Mepilex® Lite, Silicone Face, 6" x 6"	284390
Mepilex® Transfer, Silicone Face, 6" x 8"	294899
Mepilex® Transfer, Silicone Face, 8" x 20"	294599
Mepilex® UP, 4" x 4"	212199
Mepilex® UP, 6" x 6"	212399
SMITH & NEPHEW	
Allevyn Gentle Silicone Face, 2" x 2"	66802128
Allevyn Gentle Silicone Face, 4" x 4"	66802129
Allevyn Gentle Silicone Face, 6" x 6"	66802131
Alleyvn Life Silicone Face, 4" x 4"	66801748
Alleyvn Life Silicone Face, 6" x 6"	66801749

Bordered foam

Product description	MFR#
3M™	
Tegaderm™, Acrylate Adhesive, 4" x 4"	90612
Tegaderm™, Acrylate Adhesive, 5-5/8" x 6- 1/8"	90613
Tegaderm™ Foam, Silicone Adhesive, Heal Contour Dressing, 6" x 6"	90631
Tegaderm™ Foam, Silicone Adhesive, Small Sacral, 6" x 6-3/4"	90647
Tegaderm™ Foam, Silicone Adhesive, Large Sacral, 7-1/4" x 8-3/4"	90648
Tegaderm™ Foam, Silicone Adhesive, 3" x 3"	90640
Tegaderm™ Foam, Silicone Adhesive, 4" x 4"	90641
Tegaderm™ Foam, Silicone Adhesive, 6" x 6"	90642
MCKESSON BRANDS	
Foam, Acrylic Adhesive, 4" x 4"	16-4671
Foam, Acrylic Adhesive, 6" x 6"	16-4672
Foam, Silicone Adhesive, 3" x 3"	4842
Foam, Silicone Adhesive, 4" x 4"	4843
Foam, Silicone Adhesive, 6" x 6"	4844
Foam, Silicone Adhesive, 7" x 7" Sacral	4845
Foam, Silicone Adhesive, 9" x 9" Sacral	4841
Lite Foam, Silicone Adhesive, 3" x 3"	4872
Lite Foam, Silicone Adhesive, 4" x 4"	4873
Lite Foam, Silicone Adhesive, 6" x 6"	4874

Bordered foam

Product description	MFR#
MOLNLYCKE	
Mepilex® Border Flex, Silicone Adhesive, 4" x 4"	595300
Mepilex® Border Flex, Silicone Adhesive, 6" x 6"	595400
Mepilex®, Foam Dressing Border Sacrum with Silicone Adhesive, 8-7/10" x 9-8/10"	282455
Mepilex® Border Heel, Silicone Adhesive, 8-7/10" x 9-1/10"	282790
Mepilex® Border Flex Lite, Silicone Adhesive, 4" x 4"	581300
Mepilex® Post Op, Silicone Adhesive, 4" x 8"	496405
Mepilex Post Op, Silicone Adhesive, 4"x 10"	295850
Mepilex® Post Op, Silicone Adhesive, 4" x 12"	496605

Bordered foam

Product description	MFR#
SMITH & NEPHEW	
Allevyn Life, Silicone Adhesive, 4" x 4"	66801067
Allevyn Life, Silicone Adhesive, 6" x 6"	66801069
Allevyn Life, Silicone Adhesive, Heel 9-4/5" x 9-9/10"	66801304
Allevyn Life, Sacrum, Silicone Adhesive, 8-1/2" x 9"	66801307
Allevyn Gentle Border Lite, Silicone Adhesive, 4" x 4"	66800835
Allevyn Gentle Border Lite, Silicone Adhesive, 6" x 6"	66800840
Allevyn Gentle Border, 4"x 4"	66800270
Allevyn Gentle Border, 5"x 5"	66800279
Allevyn Gentle Border, 6-3/4" x 7-1/16" Multisite	66800959
Allevyn Gentle Border, 9" x 9-1/8" Heel	66800506
Allevyn Gentle Border, 8-1/2" x 9" Sacral	66801031
Allevyn Gentle Border, 4" x 8" Surgical	66800900
Allevyn Gentle Border, 4" x 12" Surgical	66800265

Non-bordered foam, antimicrobial

Product description	MFR#
MCKESSON	
Hydrophilic Foam, PHMB, 4" X 4"	4940
MOLNLYCKE	
Mepilex® Ag Silicone Face, 4" x 4"	287100
Mepilex® Ag Silicone Face, 6" x 6"	287300
Mepilex® Transfer Ag, Silicone Face, 4" x 5"	394190
Mepilex® Transfer Ag, Silicone Face, 6" x 8"	394890
Mepilex® Transfer Ag, Silicone Face, 8" x 20"	394590
SMITH & NEPHEW	
Allevyn Ag Non-Adhesive, 4" x 4"	66020978
Allevyn Ag Non-Adhesive, 6" x 6"	66020980

Bordered foam, antimicrobial

Product description	MFR#
MOLNLYCKE	
Mepilex® Border Ag, Silicone Adhesive, 4" x 4"	395390
Mepilex® Border Ag, Silicone Adhesive, 6" x 6"	395490
Mepilex® Border Post-Op Ag, Silicone Adhesive, 4" x 8"	498400
Mepilex® Border Post-Op Ag, Silicone Adhesive, 4" x 8"	498600
SMITH & NEPHEW	
Allevyn Ag Gentle, Silicone Adhesive, 5" x 5"	66800453
Allevyn Ag Gentle, Silicone Adhesive, 7" x 7"	66800454

Honey-Medical grade

MEDIHONEY®'s high osmotic effect pulls fluid from deeper tissues to the wound surface promoting autolytic debridement. The naturally low pH of MEDIHONEY® helps lower the pH of the wound environment, which can improve chronic and stalled wounds.[10]

Product description	MFR#
MCKESSON	
MEDIHONEY® Gel, 0.5 oz.	31805
MEDIHONEY® Gel, 1.5 oz.	31815
MEDIHONEY® Paste, 0.5 oz.	31505
MEDIHONEY® Paste, 1.5 oz.	31515
MEDIHONEY® Hydrogel Sheet, 2.4" x 2.4"	31622
MEDIHONEY® Hydrogel Sheet, 4.3" x 4.3"	31644
MEDIHONEY® Calcium Alginate, 2" x 2"	31022
MEDIHONEY® Calcium Alginate, 4" x 5"	31045
MEDIHONEY® Calcium Alginate, 3/4" x 12" Rope	31012

Hydrocolloid

Hydrocolloids are occlusive and water-resistant. They can be used as a primary or secondary dressing, help maintain a moist wound environment and assist in autolytic debridement.

Product description	MFR#
MCKESSON BRANDS	
Hydrocolloid, Thin 4" x 4"	1883
Hydrocolloid, Thin 6" x 6"	1884
Hydrocolloid, Film Backing, 4" x 4"	1887
Hydrocolloid, Film Backing, 6" x 7"	1888
Hydrocolloid, Foam Backing, 4" x 4"	1889
Hydrocolloid, Foam Backing, 6" x 6"	1890

Hydrogel

Hydrogels are used as a primary dressing for wounds with light or no drainage to add or maintain moisture at the wound bed and assist in autolytic debridement. To help protect peri-wound skin from maceration, apply a moisture barrier ointment or barrier film. Available in amorphous, impregnated gauze and sheet forms.

Product description	MFR#
MCKESSON BRANDS	
Hydrogel, 1 oz.	1721
Hydrogel, 3 oz.	1722
Hydrogel Impregnated Gauze, 2" x 2"	61-53022
Hydrogel Impregnated Gauze, 4" x 4"	61-53044
Hydrogel Sheet, 2" x 2"	61-82022
Hydrogel Sheet, 4" x 4"	61-82044
SMITH & NEPHEW	
INTRASITE™ Gel, 15 gram	66027311
SOLOSITE™ Gel, 3 oz.	449600

Hydrogel – with antimicrobial agent

Product description	MFR#
MCKESSON BRANDS	
Puracyn® Plus Antimicrobial Hydrogel, 3 oz.	186-6542
Silver Hydrogel 1.57oz	1726
MOLNLYCKE	
Normlgel® Ag, 1-1/2 oz.	350450

Hydrophilic wound dressing

Hydrophilic Wound Dressing provides a moist, mildly acidic environment which is conducive to wound healing. It has a patented formulation which includes zinc, Vitamins A and B6, calcium, and magnesium.

Product description	MFR#
MCKESSON BRANDS	
Hydrophilic Wound Dressings, 3 oz.	61-SPD03

Negative pressure wound therapy

Negative pressure wound therapy (NPWT) involves the application of controlled levels of sub-atmospheric (negative) pressure to a wound. NPWT may stimulate the formation of granulation tissue, increase blood flow, promote angiogenesis, reduce edema, improve wound contraction and protect from external contamination.[21] All devices listed below are considered disposable.

Product description	MFR#
3M™	
SNAP™ Dressing Kit, 10 cm x 10 cm	SKTF10X10
SNAP™ Dressing Kit, 15 cm x 15 cm	SKTF15X15
SNAP™ Dressing Kit, 20 cm x 20 cm	SKTF20X20
SNAP™ Therapy Cartridge, 60 cc-75 mmHg	SNPA075US
SNAP™ Therapy Cartridge, 60 cc-100 mmHg	SNPA100US
SNAP™ Therapy Cartridge, 60 cc-125 mmHg	SNPA125US
SNAP™ Therapy Cartridge, 150 cc-125 mmHg	SNPA125PLUS
PREVENA™ PEEL & PLACE™, Negative Pressure Wound Therapy Kit, 13 cm	PRE1101US
PREVENA™ PEEL & PLACE™, Negative Pressure Wound Therapy Kit, 20 cm	PRE1001US
PREVENA™ PEEL & PLACE™, Negative Pressure Wound Therapy Kit, 35 cm	PRE3201US
PREVENA™ Canister (5 per case), 45 mL	PRE1095
PREVENA PLUS™ Canister, 150 mL	PRE4095

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Negative pressure wound therapy | *continued*

Product description	MFR#
SMITH & NEPHEW	
PICO 7 – 1 Dressing Kit, 10 x 20 cm	66022012
PICO 7 – 1 Dressing Kit, 10 x 30 cm	66022013
PICO 7 – 2 Dressing Kit, 10 x 20 cm	66022002
PICO 7 – 2 Dressing Kit, 10 x 30 cm	66022003
PICO 7Y – Wound Kit	66022031
PICO 14 – 2 Dressing Kit, 10 x 30 cm	66022043
PICO 14 – 2 Dressing Kit, 10 x 40 cm	66022044

Non-adherent dressing

Non-adherent dressings are designed not to stick to the wound bed, resulting in less pain and trauma upon removal.

Without anitimicrobial silver

Product description	MFR#
3M™	
ADAPTIC™, 3" x 3"	2012
ADAPTIC™, 3" x 8"	2015
MCKESSON BRANDS	
Oil Emulsion, 3" x 3"	61-77041
Oil Emulsion, 3" x 8"	61-77042

Specialty absorptive dressing

Specialty absorbent dressings are highly absorbent. They help to decrease the risk of maceration and keep harmful wound components away from the wound and peri-wound skin. They contain a protective outer layer and nonadherent wound contact layer for easy removal.

Product description	MFR#
3M™	
KerraMax Care® Super-Absorbent Dressing, 4" x 4"	PRD500-050
KerraMax Care® Super-Absorbent Dressing, 5" x 6"	PRD500-100
KerraMax Care® Super-Absorbent Dressing, 4" x 9"	PRD500-120
MCKESSON BRANDS	
Super Absorbent Dressings, 4" x 5"	61-89545
Super Absorbent Dressings, 6" x 9"	61-89569
MOLNLYCKE	
Mextra® Superabsorbent, 5" x 7"	610100
Mextra® Superabsorbent, 7" x 9"	610300
Mextra® Superabsorbent, 9" x 11"	610400
SMITH & NEPHEW	
EXU-DRY™, 4" x 6"	5999004120
EXU-DRY™, 6" x 9"	5999006

Tape – Silicone

Silicone tape is ideal for minimizing pain and trauma for sensitive or at-risk skin. May be appropriate for individuals with adhesive allergies.

Product description	MFR#
3M™	
Micropore™ S Silicone Tape, 1" x 5 -1/2 yd	2770-1
Micropore™ S Silicone Tape, 2" x 5- 1/2 yd	2770-2
MCKESSON	
Silicone Adhesive Surgical Tape, 1" x 5-1/2 yd	16-48410
Silicone Adhesive Surgical Tape, 2" x 5-1/2 yd	16-48420
MOLNLYCKE	
Mepitac® Soft Silicone Tape, 3/4" x 118"	298300
Mepitac® Soft Silicone Tape, 1-1/2" x 59"	298400

Tape – Surgical

Tapes use adhesive to secure wound dressings or other devices.

Product description	MFR#
3M™	
Medipore™ H Cloth Surgical Tape, 1" x 10 yd	2861
Medipore™ H Cloth Surgical Tape, 2" x 10 yd	2862
Medipore™ H Cloth Surgical Tape, single-patient use roll, 1" x 2 yd	2860S-1
Medipore™ H Cloth Surgical Tape, single-patient use roll, 2" x 2 yd	2860S-2
Durapore™ Surgical Tape, 1" x 10 yd	1538-1
Durapore™ Surgical Tape, 2" x 10 yd	1538-2
MCKESSON BRANDS	
Transparent Surgical Tape, 1" x 10 yd	16-47210
Transparent Surgical Tape 2" x 10 yd	16-47220

Transparent film and acrylic

Transparent films and clear acrylic dressings are used as primary or secondary dressings. They help maintain a moist wound environment. These dressings are water-resistant and transparent.

Product description	MFR#
3M™	
Tegaderm™ Transparent Film, 2-3/8" x 2-3/4"	1624W
Tegaderm™ Transparent Film, 4" x 4-3/4"	1626W
Tegaderm™ Absorbent, 4-3/8" x 5"	90801
Tegaderm™ Absorbent, 3" x 3-3/4"	90800
MCKESSON BRANDS	
Transparent Film, Frame Delivery, 2-3/8" x 2-3/4"	4985
Transparent Film, Frame Delivery, 4" x 4-3/4"	4986
Transparent Film, Frame Delivery, 6" x 8"	4987
MOLNLYCKE	
Mepore® Film, 2-2/5" x 2-3/5"	270600
Mepore® Film, 4" x 5"	271500
Mepore® Film, 6" x 8-1/2"	273000
SMITH & NEPHEW	
OPSITE FLEXIGRID™, 2-3/8" x 2-3/4"	4628
OPSITE FLEXIGRID™, 4" x 4-3/4"	4630

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Xeroform dressing

Xeroform is a primary dressing that contains 3% Bismuth Tribromophenate to provide bacteriostatic properties and help reduce risk of infection and deodorize the wound. It assists in maintaining moist wound healing environment to allow for autolytic debridement for wounds with light or no drainage.

Product description	MFR#
MCKESSON BRANDS	
Xeroform with Petrolatum, 1" x 8"	2201
Xeroform with Petrolatum, 4" x 4"	2206
Xeroform with Petrolatum, 5" x 9"	2207

Wound cleanser

Wound cleansers are solutions used to remove debris and exudate from the wound surface.

Product description	MFR#
MCKESSON BRANDS	
Dermal Wound Cleanser, 4 oz.	1718
Dermal Wound Cleanser, 8 oz.	1719
Dermal Wound Cleanser, 16 oz.	1720
Saline Wound Flush, 7.1 oz.	37-6507
Winchester Labs	
Saljet® Sterile Saline Solution, 30 mL	64938-009-001

Wound cleanser

These cleansers contain antimicrobial agents if contamination is a consideration.

Product description	MFR#
MCKESSON BRANDS	
Puracyn® Plus Professional Pump Bottle, 4 oz.	186-6505
Puracyn® Plus Professional Pump Bottle, 8.5 oz.	186-6509
Puracyn® Plus Professional Flip Top Bottle, 16.9 oz.	186-6516
Puracyn® Plus Professional Spray Bottle, 16.9 oz.	186-6517
Puracyn® Plus Professional Instill Application, 16.9 oz.	186-6525
Puracyn® Plus Wound and Skin Care Solution, 8.5 oz. Pump Bottle	186-6002
Puracyn® Plus Wound and Skin Care Solution, 16.9 oz. Spray Bottle	186-6004
SMITH & NEPHEW	
Dermal Wound Cleanser, 8 oz.	59449200
Dermal Wound Cleanser, 16 oz.	449000

Wound measuring guides

These measuring guides are disposable and made for single-use.

Product description	MFR#
3M™	
6" paper ruler	533-LR/50
MCKESSON BRANDS	
Plastic circular grid	533-30012100
PURITAN MEDICAL PRODUCTS	
6" measuring guide-polystyrene shaft and foam tip	25-1506 1PF DM

McKesson Woundcare

Companion™ Pocket Guide

General note about shelf-life dating:

Shelf-life dating solely for package integrity and sterility is not usually required by the FDA for general medical devices. There may be a need for expiration dating when a particular component of a device, such as a battery or diagnostic reagent, has a finite useful life.

When the product has an expiration date, product for National Distribution must have eight (8) months minimum remaining until the expiration date.

For further information on shelf-life dating from featured suppliers, please visit their respective websites listed below.

- **mms.mckesson.com/mckesson-brands**
- **www.innovacyn.com**
- **www.molnlycke.com**
- **www.smith-nephew.com**
- **www.3m.com**
- **www.coloplast.us**
- **www.saljet.com**

Our products are available in various units of measure – from single products to cases. Contact your McKesson Account Manager or check out ***mms.mckesson.com*** to order today.

Footnotes

1. The skin protection claim does not apply to the Foaming Body Cleanser and the Antifungal Body Powder.
2. Mohammed HT, Cassata A, Fraser R, Mannion D. Trends in Pressure Injury Prevalence Rates and Average Days to Heal Associated with Adoption of a Comprehensive Wound Care Program and Technology in a National Skilled Nursing Organization. Symposium on Advanced Wound Care (SAWC) Conference. National Harbor, MD. April 26–30, 2023.
3. Customer benefits evaluation. Data on file.
4. Cornerstone VNA benefits evaluation. Data on file.
5. International Wound Infection Institute (IWII) Wound Infection in Clinical Practice. Wounds International. 2022.
6. Freyberg J., et al. Moisture Management Challenges for the WOC Nurse presented at the WOCN Society 39th Annual Conference, June 2007.
7. Sardina, Donna RN, MHA, WCC, DWC, Wound & Skin Care Pocket Guide. Wound Care Education Institute®. 2017. Print.
8. Ratliff, Catherine R, and Tomaselli, Nancy. Guideline For Prevention and Management of Pressure Ulcers. Mount Laurel: Wound, Ostomy and Continence Nurses Society, 2010. Print.
9. Raymundo J, and Wells J. Wound debridement. In: Ed. Bryant RA. Acute and chronic wounds: nursing management. 2nd ed. St Louis: Mosby, 2000. Print.
10. MEDIHONEY® is a registered trademark of Medihoney Pty Ltd. and licensed to Derma Sciences, Inc. MEDIHONEY® is not a private label product of McKesson but is available for distribution through McKesson's exclusive brand of Advanced Wound Care products.
11. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. Emily Haesler (Ed.) EPUAP/NPIAP/PPPIA: 2019 http://www.internationalguideline.com/static/pdfs/Quick_Reference_Guide-10Mar2019.pdf.
12. LeBlanc K et al. Best practice recommendations for the prevention and management of skin tears in aged skin. Wounds International 2018.

Footnotes

13. Freyberg J., et al. Moisture Management Challenges for the WOC Nurse
presented at the WOCN Society 39th Annual Conference, June 2007.

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16. O'Brien C. Malignant wounds: managing odour. Can Fam Physician. 2012 Mar;58(3):272-4; e141-3. PMID: 22518896; PMCID: PMC3303648.

17. Ayello E, Levine J, Langemo D, et al. Reexamining the literature on terminal ulcers, SCALE, skin failure, and unavoidable pressure injuries. Adv Skin Wound Care. 2019;32(3):109-121.

18. Kennedy terminal ulcer/palliative care and hospice care. WoundSource Practice Accelerator. 2018.

19. Vorbeck E. Evaluation of a Skin Fold Management Textile with Antimicrobial Silver Complex in a Variety of Case Studies.

20. InterDry® is a skin protectant for the management of skin folds and other skin-to-skin contact areas. It reduces microbial colonization in the fabric. This single use fabric provides moisture translocation to keep skin dry while the antimicrobial in the fabric reduces odor. The safe use of InterDry® fabric during pregnancy, lactation and on children has not been demonstrated. Although many patients benefit from the use of this device, results may vary. See the device labeling for detailed information including the indication, contraindications, warnings, precautions, and potential complications/adverse events. For further questions, call Coloplast Corp. at 1-800-533-0464 and/or consult the company website at **www.coloplast.us**

21. Nie B, Yue B. Biological effects and clinical application of negative pressure wound therapy: a review. J Wound Care. 2016 Nov 2;25(11):617-626. doi: 10.12968/jowc.2016.25.11.617. PMID: 27827278. 126 .

McKesson Brands Guarantee

If you are not completely satisfied with any McKesson Brands product, you may return it for a full refund or credit within 12 months from the purchase date. McKesson Brands' satisfaction guarantee is limited to products purchased directly from McKesson. If a McKesson Brands product is not purchased directly from McKesson, any return request or request for refund must be directed to the selling party.

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Wound Care Education Institute

Wound Care Education Institute (WCEI) has contributed to this content.

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