Negative pressure wound therapy: clinical utility

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Abstract: Negative pressure wound therapy (NPWT), also known as topical negative pressure therapy, has been increasingly used in health care for the management of a wide variety of wounds over the last 2–3 decades. It is an advanced therapy that can be helpful to accelerate wound healing in both acute and chronic wounds by delivering negative pressure (suction) to the wound bed. More recent advancements in the application of NPWT have provided clinicians with wider choices of utilization. There are now devices available that can deliver irrigation to the wound bed, be used for closed surgical incisions, or are disposable and highly portable. Systematic reviews considering NPWT have been published previously. These usually focus on one wound group or device and fail to offer practical clinical guidance due to the scrutiny offered to the evidence via a systematic review process. Here, an overview of the history of NPWT, the varieties of device available, their wide clinical application, and the evidence to support its use are explored in a pragmatic way.

Keywords: negative pressure, wound, incision, healing, pain

History of negative pressure wound therapy
In 1989, Chariker et al.1 published a paper describing a wound dressing technique using gauze filler, drains, and continuous closed (possibly wall or portable) suction to assist wound healing and exudate management. Papers had been published earlier than this describing similar techniques using a syringe and catheter,2 water seal drainage bottles,2 or glass chambers.4,5 In 1997, Argenta and Morykwas published two papers7,8 describing their technique delivering the same treatment using a foam wound filler and pump, called vacuum-assisted closure (VAC) therapy. Over the next 9 years, possibly due to patents and robust marketing strategies, VAC® therapy (distributed by KCI Medical) became the only available product to deliver negative pressure wound therapy (NPWT) worldwide.

In 2006, Blue Sky Medical9 successfully challenged some of the patents held by KCI Medical and Wake Forest University, and opened up the market to alternative modes of delivering NPWT. Since that time, several manufacturers have brought competitively priced products to the market, some of which have also had patent battles in the courts with KCI Medical and Wake Forest University.10

How does NPWT work?
Through the use of a wound filler contact material (foam, gauze, or drain), negative pressure is applied directly to the wound bed using an electrically, battery, or mechanically
powered pump. An airtight vacuum seal is required in order to achieve this. The level of negative pressure delivered to the wound may vary dependent upon manufacturer, wound type, and wound filler. Early research undertaken by Morykwas et al demonstrated improved blood flow to the wound with negative pressures set at higher levels. This has been both supported and disputed in later studies.

The benefits of using NPWT include enhanced healing, management of exudate, reduced dressing changes compared with other dressings, reduced nurse time, and improved quality of life. Wound healing is thought to be assisted by provision of a moist environment, interstitial fluid removal, and enhanced tissue perfusion. Others have reported fluctuations in blood flow according to distance from the wound edge and the level of negative pressure applied to the wound. This may be a useful finding to consider when using NPWT on wounds with compromised vascularity, such as in patients with diabetic foot or lower limb arterial disease where caution may be required with use if reperfusion is diminished. Claims by Morykwas et al of a reduction in bacterial count have not been further supported by research.

When can NPWT be used?
NPWT is suitable for use in all but a few wounds (including closed surgical or grafted wounds) and requires caution in others. (Table 1). There is evidence of NPWT being used with good clinical effect in a wide variety of wounds and clinical situations (Table 2).

<table>
<thead>
<tr>
<th>Contraindicated wounds</th>
<th>Rationale</th>
<th>Use with caution</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wounds involving untreated osteomyelitis</td>
<td>If the wound closes over an underlying osteomyelitis there is a risk the wound will recur</td>
<td>Wounds with visible fistula</td>
<td>Isolate fistula to prevent further deterioration</td>
</tr>
<tr>
<td>Wounds exposing blood vessels, nerves, anastomotic sites or organs, or with an unexplored fistula</td>
<td>Risk of rupture to blood vessel, anastomotic site, or organ; risk of nerve damage; risk of further deterioration of fistula</td>
<td>Wounds with exposed bone or tendon</td>
<td>Isolate bone or tendon from direct pressure by protecting with a liner dressing to prevent drying out</td>
</tr>
<tr>
<td>Wounds including open joint capsules</td>
<td>Risk of drainage of synovial fluid</td>
<td>Clotting disorder or anticoagulant use</td>
<td>Compromised microvascular blood flow to the wound bed</td>
</tr>
<tr>
<td>Skin malignancy and excised skin malignancy except for palliation</td>
<td>Risk of exacerbation of growth of malignant cells</td>
<td>NPWT will not facilitate debridement of necrotic tissue</td>
<td>Risk of further compromise of vascular supply</td>
</tr>
</tbody>
</table>

Abbreviation: NPWT, negative pressure wound therapy.
Where bowel is exposed within either an intentionally laid open or a dehisced abdominal wound, a specialized membrane liner dressing is used in combination with either foam or gauze to prevent fistulation of the bowel. Fistula formation has been reported in 7% of patients where NPWT has been used over an open abdomen.

There is an absence of clinical comparative trials with regard to channel drains. However, a channel drain can be used for a tracking sinus wound of considerable depth or length. The narrow lumen of a channel drain can be inserted into sinuses with or without gauze to help facilitate closure of the sinus. The origin of the sinus should be explored prior to commencing NPWT via scan, ultrasound, magnetic resonance imaging, or computed tomography. This can help eliminate a deeper source for the sinus origin that may need to be resolved prior to attempting closure.

### Pump type

There are currently several commercially available pumps on the market. Rather than discuss them by manufacturer, they are described here via functionality.

#### Traditional negative pressure delivery

These pumps can be used with gauze and/or foam filler, and may be either cumbersome or smaller and portable, commonly using a carry bag. The canisters in use with these pumps will usually hold from 300 mL to 1,000 mL of wound exudate. They are electrically powered and have a battery backup.

#### Disposable negative pressure pumps

These are sized to be hand-held, and are battery or mechanically powered. They may use a dressing or a canister to hold exudate. These are disposed of once therapy or dressing life is over.

#### Negative pressure pumps for surgical incision wounds

There are two commercially available pumps that use flat absorbent dressings for use directly over closed surgical wounds. These are small and easily carried pumps, and are disposable once the dressing life has expired or therapy is completed. It is not clear in the literature whether these devices reduce the incidence of surgical site dehiscence and infection. Stannard et al were early authors describing the use of NPWT to prevent surgical incision dehiscence and infection in patients with orthopedic trauma wounds. Their small randomized study was inconclusive. Some later

### Table 2 Published papers utilizing NPWT for a wide variety of wound types

<table>
<thead>
<tr>
<th>Reference</th>
<th>Wound type</th>
<th>Paper type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baharestani et al</td>
<td>Neonatal and pediatric</td>
<td>A retrospective case study of 24 children aged</td>
</tr>
<tr>
<td></td>
<td>population</td>
<td>between 14 days and 18 years</td>
</tr>
<tr>
<td>Butter et al</td>
<td>Pediatric population</td>
<td>Retrospective case review</td>
</tr>
<tr>
<td>Binet et al</td>
<td>Giant omphalocele</td>
<td>Case study report of three babies aged</td>
</tr>
<tr>
<td></td>
<td>management</td>
<td>11 days to 5 months</td>
</tr>
<tr>
<td>Yu et al</td>
<td>Post-sternotomy</td>
<td>Systematic review</td>
</tr>
<tr>
<td></td>
<td>mediastinitis</td>
<td></td>
</tr>
<tr>
<td>Gupta and Ichioka</td>
<td>Pressure ulcers</td>
<td>Literature review and case studies</td>
</tr>
<tr>
<td>Ousey et al</td>
<td>Spinal wounds</td>
<td>Systematic review</td>
</tr>
<tr>
<td>Davies et al</td>
<td>Exposed brain</td>
<td>Letter reporting single case study</td>
</tr>
<tr>
<td>Falagas et al</td>
<td>Sternal wound</td>
<td>Meta-analysis</td>
</tr>
<tr>
<td></td>
<td>infections</td>
<td></td>
</tr>
<tr>
<td>Gupta</td>
<td>Skin graft</td>
<td>Literature review</td>
</tr>
<tr>
<td>Llanos et al</td>
<td>Pleural empyema</td>
<td>Randomized controlled trial</td>
</tr>
<tr>
<td>Sziklai et al</td>
<td>Chronic leg ulcers</td>
<td>Randomized controlled trial</td>
</tr>
<tr>
<td>Vuerstaek et al</td>
<td>Severe military lower</td>
<td>Case studies</td>
</tr>
<tr>
<td>Jeffery et al</td>
<td>Combat wounds</td>
<td>Retrospective case review</td>
</tr>
<tr>
<td>Penn-Barwell et</td>
<td>Diabetic foot ulcer</td>
<td>Systematic review</td>
</tr>
<tr>
<td>Noble-Bell and</td>
<td>Burns</td>
<td>Systematic review</td>
</tr>
<tr>
<td>Forbes et al</td>
<td>Open abdomen</td>
<td>Single case studies</td>
</tr>
<tr>
<td>Molnar et al</td>
<td>Burns</td>
<td>Single case studies</td>
</tr>
<tr>
<td>Gonzalez Alana et</td>
<td>Closed incisional</td>
<td>Literature review and case studies</td>
</tr>
<tr>
<td>Stannard et al</td>
<td>wounds</td>
<td>Randomized controlled trial</td>
</tr>
<tr>
<td>Masden et al</td>
<td>Surgically closed</td>
<td>Retrospective review</td>
</tr>
<tr>
<td>Suzuki et al</td>
<td>wounds in open</td>
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<td></td>
<td>fractures</td>
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</table>

of a best practice statement and studies comparing gauze with foam. It has been demonstrated that gauze filler achieves the same clinical outcomes whilst reducing pain for the patient at dressing change, saving nursing time, and reducing costs.

In a bid to find a cheaper wound contact filler, Tuncel et al have described similar effects using a sterilized, store-bought loofah sponge when compared with foam and gauze in in vivo studies of acute wounds in rabbits. Perez et al also describe creating a “homemade” system to deliver negative pressure in Haiti, where funding for the commercially available systems is not available. They used the foam from a surgical hand scrub brush as the wound contact material. Both groups reported effective clinical outcomes.
Irrigation negative pressure pump

There are two commercially available irrigation pumps reported in the literature that can intermittently deliver irrigation fluids to the wound with negative pressure. Various instillation fluids have been described, including insulin, antibiotics, Dakin’s solution, and polyhexamethylene biguanide. This technique of instilling fluids into the wound while intermittently delivering negative pressure has been described previously. The main outcome for this mode of delivery is prevention or eradication of infection, and it has been shown to be useful for osteomyelitis and to improve retention rates of infected orthopedic implants. A recent international consensus guideline on the use of instillation therapy offers recommendations as to suitable wound types and instillation fluids.

Adapted or “home-made” systems

Several authors have described using the hospital central suction system to apply negative pressure to wounds. The cost savings in comparison with a commercial pump system are favorably portrayed.

Clinical effectiveness of NPWT

It could be argued that NPWT sees the highest number of randomized clinical trials, systematic reviews, and consensus best practice guidelines in publication than any other wound treatment modality. NPWT has been clinically evaluated and compared with other wound treatments, one NPWT wound contact material has been compared with another, the costs of delivering NPWT have been analyzed, and patient-centered outcomes such as pain have also been considered. Meta-analyzing the different controlled trials can be difficult due to the heterogeneity of the wound types studied. The methodology of some of the randomized clinical trials can be criticized; often power, blinding issues, potential bias, and randomization systems are not discussed. As such, three of four Cochrane reviews have been unable to recommend the use of NPWT over any other treatment modality. The fourth suggests that when used with the diabetic foot ulcer patient, there may be a benefit to healing and reduced risk of further amputation. However, they do recommend caution when considering the results because of the risk of bias around adequate blinding. In a recent BMJ rapid response, Tovey and Bero quote: “Few now support the view that the randomized controlled trial is the only meaningful research to guide rational decision-making, or that statistical significance is the only determinant of effectiveness.” When considering effectiveness, the clinician must consider not just the evidence base but also take a broader view incorporating clinician experience and patient preference. When it comes to NPWT, it would seem clinicians continue to utilize this modality in many more advancing ways without what Cochrane can agree is a robust evidence base. As is often the case in medicine, NPWT was created by innovative clinicians who needed to solve a clinical problem. Commercial companies have then produced products that will deliver the innovation to a wider market. Innovative clinicians take these commercial products and adapt them to help solve a clinical problem. And so the cycle goes on. Innovative risk-taking clinicians drive medical advancement which, in turn, feeds the randomized clinical trial to prove the effectiveness of the innovation. However, lack of proof via randomized clinical trial should not then halt the use or advancement of these treatments. Lack of evidence of effect is not the same as evidence of no effect. Policy makers and budget holders need to be mindful of this chicken and egg scenario.

As this is not a systematic review of NPWT, it highlights only some of the studies that have claimed to demonstrate clinical effectiveness and/or cost-effectiveness of NPWT, without critiquing the methodology that might challenge their findings.

Reduction in wound size

NPWT using a foam contact layer has been shown to reduce open wound size and volume to a statistically significant degree when compared with alternative treatment modalities. However, in contrast, Braakenburg et al reported no statistical significance when compared with what they describe as modern dressings (hydrocolloid, alginate, acetic acid, and EUSOL [Edinburgh University Solution of Lime]) except within the patient population with cardiovascular disease and/or diabetes.

Cost-effectiveness

Where cost-effectiveness has been evaluated, it has been demonstrated that NPWT is more cost-effective than alternatives. However, the costs are balanced by a reduced number of dressing changes and nurse time required to change the dressings. To a finance director, the cost of NPWT can seem extremely high. As such, it is important to understand how reduced healing time can impact on the overall costs involved when negotiating for the use of
NPWT in times of austerity. The larger portion of the cost-effectiveness papers consider KCI Medical VAC therapy as the product of comparison. More recently, the costs of using a gauze-based system have been compared favorably with KCI Medical VAC therapy.30

Foam versus gauze filler

Studies comparing effectiveness between gauze-based and foam-based NPWT have considered the difference in healing rates,50 pain at dressing change,50,51 contraction,89,90 scar tissue depth,91 tissue formation91,92 and deformation,92 and microvascularity effect.19,92

It would seem that there is very little difference in clinical outcomes between the two types of contact media. However, it has been demonstrated that less force is required to remove the gauze medium,92,93 which may go some way to explaining the finding that patients report higher pain levels50,51 when using foam, which can allow tissue ingrowth.93 It has also been shown that the granulation tissue forming under foam is thicker with increased scarring.93 Plastic surgeons have identified this as a cause of frailer skin grafting, and as such, some have switched to using gauze to prepare a wound for skin grafting.93

Level of negative pressure

The level of negative pressure required will vary according to the manufacturer’s instructions, the contact material used, and patient acceptability, but is usually between −50 mmHg and −200 mmHg. For instance, gauze requires a much lower negative pressure to collapse and conform to the wound bed than a denser foam.

Initial studies8 considering the level of negative pressure required to be effective suggested that 125 mmHg resulted in optimal blood flow. However, later studies have not been able to achieve consensus with regard to level of pressure and what effect this has on blood flow.11 Very often the level of pressure selected is guided by the manufacturer. Clinicians may decide to set pressures lower to reduce pain or higher to expedite exudate removal.21

Effect of wound liners on pressure

One study considered the effect that a wound liner contact layer may have on the level of pressure delivered to the wound bed.94 Three liners were evaluated on healthy skin, and so conclusions as to translation when using on the wounds themselves need to be drawn with caution. However, what can be concluded is that the use of Jelonet® (Smith and Nephew) adversely affects the negative pressure, thereby rendering its use impractical where negative pressures need to be achieved, but is potentially useful where structures, such as fistulas, bone, or vascular grafts, may need to be isolated from negative pressure.

Using NPWT in clinical practice: decision-making and application tips

When deciding to use NPWT, several considerations are necessary:

- Suitability of the wound for the therapy
- Risk factors and risks of harm by using the device
- Suitability of the patient for the therapy
- Which device and contact medium will best suit the clinician and patient outcomes
- What level of pressure is best for the wound and desired outcomes
- Length of time treatment is expected to be needed
- Who will manage the ongoing dressing changes and in what setting
- Use in the community
- Willingness of patient to receive the treatment

Most wounds are suitable for the use of NPWT, taking into consideration the aforementioned contraindications. Rather than considering suitability of use by wound type, it is more reasonable to consider suitability by wound conditions. For instance, a wound with an exposed blood vessel or necrotic tissue present may be contraindicated unless the vessel can be safely protected or the necrotic tissue can be debrided. A wound too close to a functioning anus may lead to challenges gaining a secure seal, rendering NPWT impractical to use.

Of course, the wound belongs to a person, whose ability to cope with the pump and therapy also needs to be taken into consideration.21 Some questions to consider prior to commencing therapy are:

- How mobile is this person and will the pump restrict their mobility?
- How heavy will the pump be for them to carry?
- Will the therapy be used in a hospital setting or in the patient’s residential setting?
- Are there any safety issues that need to be considered, for instance, trip hazards, poor vision, hearing problems, frail or elderly living alone?
- How readily will the individual cope with any alarms and will they be able to follow processes to resolve these?
- Where pumps are owned or rented by individual organizations, how will the pump be returned to that organization when therapy is discontinued?
Does the patient have cognition and are they willing to comply with the therapy?

How painful is the wound and dressing change? Where dressing changes are painful, nitrous oxide may reduce this, but this would need to be administered in the hospital setting as very often this is not available in the community setting.

Dressing changes will be undertaken 2–4 times per week dependent upon the contact dressing used, manufacturer guidance, exudate levels, and patient preferences.

Transition of care from the hospital to the community setting with NPWT in place requires good communication between organizations. Very often, a tissue viability nurse from each organization will be involved in this transition. Papers describing processes to aid this transition have been published previously.\(^1\)\(^7\) Accepting NPWT for use in the community setting can expedite earlier discharge from hospital and reduce the number of community nursing visits for dressing changes, both of which reduce the costs of overall care for patients with wounds that can be managed with NPWT.\(^7\)

**Tips for successful dressings**

In order for NPWT to effectively accelerate wound healing it requires good contact with the wound bed and a vacuum achieved by sealing the dressing from air leaks. There are a number of other considerations to ensure safety during therapy use (Figure 1).

**Wound filler and pump selection**

The selection of type of wound filler and pump may be based on several considerations (Figure 2). In some organizations, this may be limited to which system is available for use.

**Conclusion**

NPWT is a widely utilized treatment for many different wound types. Despite the quality of trial methodology depreciating statistically significant findings, NPWT has been shown to be effective in accelerating wound healing and reducing treatment costs. Advances in the development of NPWT products are providing clinicians with an expanding choice of therapeutic modalities to use. Further research is needed to demonstrate the effectiveness of NPWT when used to prevent surgical incision dehiscence and infection.

**Disclosure**

The author reports no conflicts of interest in this work.

**References**


