**Urgotul®**: a novel non-adherent lipidocolloid dressing

Meaume S, Senet P, Dumas R, Carsin H, Pannier M, Bohbot S

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The enclosed peer-reviewed journal article is provided in the interest of free exchange of truthful scientific information. **Restore®** wound care dressings* are intended for single use in the management of partial- and full-thickness wounds.

In this article, the authors note that the contact layer dressing was left in place in some cases for five to 10 days. The interval between dressing changes beyond seven days is not recommended by Hollister Wound Care LLC, and has not been cleared by the FDA.

**Warnings and Precautions**: Do not re-use the dressing. Restore Contact Layer Dressing tends to stick to latex gloves. Moisten latex gloves with normal sterile saline prior to use. Store the dressing flat and at room temperature.

**Contraindications**: Restore Contact Layer Dressing should not be used on individuals who are sensitive to or who have had an allergic reaction to the dressing or one of its components.

* The product cited in this article – Urgotul® (Laboratoires URGO, Dijon, France) – is marketed in the U.S. by Hollister Wound Care LLC as Restore® Contact Layer Dressing with TRIACT™ Technology. (In the United States, lipidocolloid technology is known as TRIACT Technology.)

* The Instructions for Use (IFU) is attached. The full IFU – written in English, French and Spanish – is available at: [www.hollisterwoundcare.com/products/ifus.html](http://www.hollisterwoundcare.com/products/ifus.html)
**Urgotul®: a novel non-adherent lipidocolloid dressing**

S Meaume, P Senet, R Dumas, H Carsin, M Pannier, S Bohbot

**Abstract**

Urgotul® belongs to a new class of non-adherent dressings: the lipidocolloid dressings. It is composed of an open weave polyester mesh impregnated with hydrocolloid polymers dispersed within petrolatum. The first clinical trial data are presented. Efficacy and safety were evaluated in a multicentre non-comparative trial involving 92 patients treated to healing or up to 4 weeks. Adult outpatients with acute wounds (n=34), leg ulcers (n=24), other chronic wounds (n=14) or with second-degree burns (n=20) were included. Results showed 32.4% (n=11) of the acute wounds, 12.5% (n=3) of the leg ulcers and 14.3% (n=2) of the other chronic wounds completely healed before 4 weeks. Surface areas decreased on average by 76.4%, 63.5% and 44.2% at study endpoint respectively. For burns, 19 patients healed (95%) within 5–19 days.

A total of 771 dressing changes were performed during the course of the study. Dressing application was considered as easy or very easy in 90% or more of the changes and there was no difficulty in removing the dressing in about 95% of the cases. Safety was good with five reports of a transitory local adverse event, probably dressing-related, being observed. Two patients (2.2%) prematurely stopped treatment because of moderate periwound erythema. Urgotul® is a highly promising new dressing which is currently undergoing further, comparative, clinical evaluations.

Nevertheless, owing to their non-existent absorbency, secondary absorbent dressings may be required. Currently, such impregnated gauze dressings are widely used in burns therapy and acute wounds, and to a lesser extent in the treatment of chronic wounds (Lawrence, 1993; Moody, 1995; Williams, 1995; Dealey, 2000).

In order to combine desirable properties of hydrocolloids with those of petrolatum gauze, a new generation of dressing has been developed, the lipidocolloid dressings. The first representative of this new class of dressing is Urgotul®

**Dressing selection should have the main objectives of promoting and maintaining a favourable environment to facilitate healing (Eaglstein and Falanga, 1997). Most of the published clinical data support the use of dressings that promote microenvironmental factors, such as optimal oxygen tension, pH and humidity, which stimulate more rapid wound healing, in particular those that support a moist wound environment. In addition, the choice of dressing will be influenced by clinical factors, such as the type of wound, position, presence of debris or infection, level of exudate and patient comfort.**

Further, an optimal wound dressing should meet the following criteria:

- Maintain a moist environment at the wound/dressing interface
- Remove excess exudate
- Have thermal insulation properties
- Allow gaseous exchange
- Be impermeable to bacteria, in and out of the wound environment
- Be free of particles and toxic wound contaminants
- Permit trauma and pain-free removal (Dealey, 1993).

Taking into account the fact that wound healing takes place in three phases (inflammation, tissue formation, and tissue remodelling) that overlap in time, it is unlikely that any one dressing will have an optimal performance for all of these stages (Singer and Clark, 1999).

The categories of modern wound dressings broadly include films, foams, hydrocolloids and alginates. Foams and alginates are generally appropriate for wounds with a significant amount of exudate (Morgan, 1996; Schultze et al, 2001). Hydrocolloids are designed for wounds with mild to moderate drainage. Films are used in superficial wounds with minimal drainage. Films are used in superficial wounds with minimal drainage (Choucair and Phillips, 1998; Bradley et al, 1999; Briggs, 2000).

When granulation tissue is present, exudate levels low, and re-epithelization of wound underway these dressings may not be totally appropriate. In this instance, non-adherent silicone or perforated plastic film dressings, or petrolatum gauze are often used (Williams, 1995; Thomas, 1997; Dealey, 2000).

Such gauzes are regarded as hypoallergenic dressings; they act as interfaces that cling and conform to the wound without adherence. However, in practice this is not always the case (Thomas, 1990; Moody, 1995); because of the physiologically inert nature of petrolatum they can be used on any wound, acute or chronic.
each evaluation the general appearance of the wound, surface area and dressing tolerability (i.e. signs of local erythema, pain, maceration, malodour, bleeding, infection) were recorded.

After the inclusion of 72 patients with acute or chronic wounds, the trial was extended to include partial-thickness burns. Seven burn units participated in the extension of this study. Patients with clean, non-infected second-degree burns of less than 200cm² area, and any origin or location, were enrolled.

At the inclusion visit the general appearance of the lesion and planimetry were recorded. Urgotul® was applied after usual lesion cleansing (Figure 2).

Urgotul®: a new non-adherent petrolatum and hydrocolloid impregnated dressing

Urgotul® is composed of a 100% polyester crosswise open weave impregnated with hydrocolloid polymers dispersed within a petrolatum impregnated mesh. Its macroscopic aspect is that of a non-greasy light and soft gauze which adapts itself easily to wound shape (Figures 1a and 1b). Urgotul® will not fray, so no microfibres will be released into the wound.

In contact with exudate, hydrocolloid polymers are hydrated and constitute with the petrolatum part of the dressing, a lipidocolloid interface which is designed to reduce adhesion to the wound surface. Urgotul® has an appreciable fluid absorbive capacity.

The lipidocolloid interface is very cohesive, preventing release of petrolatum on to the wound surface and facilitating dressing removal. In addition, the open weave of the polyester is non-deformable and maintains the 500µm size when impregnated, thus reducing the growth of granulation tissue growing through and the consequent risk of trauma on removal. This dressing maintains a pH of 6.5–7.5, according to the wound environment.

Urgotul® is indicated for the treatment of superficial acute or chronic exuding wounds at the granulation and re-epithelization stages of the healing process. It is a non-adherent primary wound contact layer that should usually be changed every 2–3 days, but can be left in place for longer (6 days) on low or lightly exuding wounds. As a result of the low adherence to the wound, painfree and non-traumatic (no bleeding) removal are to be expected (Moody, 1992; Hollinworth, 1995; Williams, 1996). In practice, this has been found to be the case (Benbow, 2002).

Clinical experience with Urgotul®

Methods

The efficacy and safety of Urgotul® were evaluated in a multicentre non-controlled clinical trial involving a total of 92 patients followed up to healing or up to 4 weeks. This trial was approved by the relevant ethics committees and written agreement obtained before the start of treatment.

Patients aged 18 years or over, with acute (duration of wound ≤ 28 days) or chronic (duration > 28 days) wounds were included by 20 centres in France. Only clean/debrided wounds of surface area less than 100cm², without signs of infection, and of any aetiology except cancerous lesions, were included.

At the inclusion visit, a complete patient history was recorded, clinical evaluation of the wound performed, including photograph and planimetry measurement, and the first Urgotul® dressing was applied after cleansing the wound with physiological saline.

Thereafter, patients were seen at least once per week for evaluation or more often for dressing changes, as required. At each evaluation the general appearance of the wound, surface area and dressing tolerability (i.e. signs of local erythema, pain, maceration, malodour, bleeding, infection) were recorded.

After the inclusion of 72 patients with acute or chronic wounds, the trial was extended to include partial-thickness burns. Seven burn units participated in the extension of this study. Patients with clean, non-infected second-degree burns of less than 200cm² area, and any origin or location, were enrolled.

At the inclusion visit the general appearance of the lesion and planimetry were recorded. Urgotul® was applied after usual lesion cleansing (Figure 2). Patients were then seen on a
weekly basis up to healing or up to 4 weeks for evaluations or more often, as required, for dressing changes. At each visit, surface area and dressing conformability, adhesion and tolerability were recorded.

Data from all 92 patients enrolled were included in the descriptive analysis. The progress of wound surface area over the 4-week follow-up period (digitized from the tracings by planimetry) was calculated with the last observed value carried over. Tolerability and local or general adverse events were descriptively reported. No statistical tests were performed. Results are presented as means or percentages.

**Results**

**Patients**

Seventy-two patients with acute or chronic wounds (excluding burns) were enrolled in the first part of the trial (Table 1). The main baseline characteristics of these subjects are presented in Table 1. Fifty-four per cent (n=39) of the patients were females. The mean age of the population ranged 68–73 years. Thirty-four wounds were acute with a mean duration of 10.2 days; these were mainly of a traumatic or postoperative aetiology and were located on the lower limbs in most cases. Their mean baseline surface area was 19.1±(SD) 21.0cm².

Among the 38 chronic wounds, 24 were leg ulcers (venous or arterial; mean baseline area: 19.1±35.5cm²) and were present for 9.6 months on average (in one case a 2-day-old recurrent venous ulcer was classified as a chronic wound). The other 14 chronic wounds (mean duration of 3.2 months, mean baseline surface area 10.3±7.2cm²) were principally pressure ulcers (five cases) or amputation stump wounds (four cases). On inclusion 25% and 90% of acute and chronic wounds were in turn completely covered with granulation tissue.

In the series of burned patients (Table 2), 20 subjects with partial-thickness second-degree burns were included. Their mean age was 39.5 years. They were seen on average 2.3 days after the injury. The site of the burn was mainly the lower limbs and the hands.

**Drop-outs**

Fifteen patients (20.8%) out of the 72 first included patients dropped out (Table 3). Main reasons for this were hospitalization (four cases) and need for skin grafting (four cases). The remainder dropped out for other unrelated reasons. Occurrence of a local adverse event or wound deterioration were reported in two and three patients respectively. One dropout was reported in the 20 burned patients. In this patient a partial necrotic zone appeared at treatment day 20 and the continued use of Urgotul® was regarded as clinically inappropriate.

**Healing rate**

In the first part of the study, 16 wounds (22.2%) healed before the end of the 4-week follow-up period. The percentage of patients who healed in this period was 32.4%, 12.5% and 14.3% respectively in the acute wounds, leg ulcers and other chronic wounds (see Table 3).

Compared with baseline values, surface areas decreased on average by 76.4%, 63.5% and 44.2% respectively at study end point in the acute, leg ulcers and chronic lesions.

Regarding the burned lesions, 19 patients healed (95.0%) during the course of the study. Complete healing was obtained within 5–19 days (11.0±4.5 days on average).

**Dressing changes**

In the first part of the study, 771 dressing changes were performed (Table 4); this was approximately 11 changes per wound. Urgotul® was changed every 2–2.3 days on average but was left in place in some cases from 5–10 days. Dressing application was considered as ‘easy’ or ‘very easy’ in over 90% of the changes and no instance of ‘difficult to remove’ recorded. Dressing changes were generally painless and maceration not observed. The conformability of the dressing to the wound shape was considered as appropriate in almost all of the acute wounds and less often in chronic wounds (poor conformability noted in 11% and 14% of the changes respectively). No or slight adhesion of the dressing was observed in more than 90% of dressing changes.

In the burns group, 97 dressing changes were conducted. Dressing application and removal were considered as ‘easy’ or ‘very easy’ in 81% and 79% respectively of the changes. The wear time ranged from 2–5 days (mean 2.5 days). As
anticipated, dressing changes were less frequently reported as painless compared with the acute and chronic wounds. Conformability was considered ‘very good’ in 62% of the cases (the remaining 38% where conformability was less were especially burns located on the fingers). No adherence of the dressing to the wound was noticed in 67% of the cases.

Local tolerability
In ulcers, acute and chronic wounds, a total of seven local adverse events (Table 5) were recorded in seven patients (7.6% of the total population). Three of these patients were treated for an acute wound. In two cases only, the occurrence of periwound erythema was the reason to stop the study dressing. In chronic wounds, one extension of ulceration of the wound edges was observed in a patient treated for an amputation stump wound, and a transitory overgranulation was noted in a post-traumatic wound. For the other events there was no causal relation to Urgotul®.

In two patients (10.0%) out of the 20 treated for second-degree burns, a local adverse event was reported, considered by the investigators as ‘probably’ related to the dressing. This was a slightly painful and transitory inflammatory reaction in one case and a painful removal of the dressing on one occasion in the other. Otherwise, these two events did not justify the stopping of Urgotul® application.

Discussion and Conclusions
It is vitally important that the delicate newlyformed tissues that appear in wounds undergoing granulation and re-epithelization are protected from trauma. Since the development of tulle gras in the early 20th century there have been many dressing developments for superficial or partial-thickness wounds. Not all of these have been successful as non-adherent and painfree products (Williams, 1996; Schultze et al, 2001).

Table 1. Baseline patients’ characteristics (72 first inclusions)

<table>
<thead>
<tr>
<th></th>
<th>Acute wounds (n=34)</th>
<th>Chronic wounds (n=38)</th>
<th>Others (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (F/M)</td>
<td>50.0%/50.0%</td>
<td>62.5%/37.5%</td>
<td>50.0%/50.0%</td>
</tr>
<tr>
<td>Age (mean years)</td>
<td>73</td>
<td>72</td>
<td>68</td>
</tr>
<tr>
<td>Body weight (kg; mean)</td>
<td>68</td>
<td>71</td>
<td>67</td>
</tr>
<tr>
<td>Duration of the wound</td>
<td>10.2 days</td>
<td>9.6 months</td>
<td>3.2 months</td>
</tr>
<tr>
<td>(means and extremes)</td>
<td>(0–28 days)</td>
<td>(2 days–36 months)</td>
<td>(1–8 months)</td>
</tr>
<tr>
<td>Type of wounds and frequency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postoperative wound</td>
<td>20</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Traumatic wound</td>
<td>11</td>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>2</td>
<td>–</td>
<td>5</td>
</tr>
<tr>
<td>Leg ulcer</td>
<td>–</td>
<td>24</td>
<td>–</td>
</tr>
<tr>
<td>Amputation stump</td>
<td>1</td>
<td>–</td>
<td>4</td>
</tr>
<tr>
<td>Burn sequelae</td>
<td>–</td>
<td>–</td>
<td>3</td>
</tr>
<tr>
<td>Wound sites (number of patients)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pelvic girdle</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Upper limbs</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Lower limbs</td>
<td>22</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>Heel</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean wound surface area (cm²)</td>
<td>19.1±21.1</td>
<td>19.1±35.5</td>
<td>10.3±7.2</td>
</tr>
<tr>
<td>(mean ± SD and extremes)</td>
<td>(0.6–103.9)</td>
<td>(0.2–170.5)</td>
<td>(0.6–30.4)</td>
</tr>
<tr>
<td>Granulation tissue over whole surface (% of wounds)</td>
<td>50%</td>
<td>25%</td>
<td>43%</td>
</tr>
<tr>
<td>Previous dressing (% of wounds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>29%</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Petroleum dressings</td>
<td>29%</td>
<td>48%</td>
<td>57%</td>
</tr>
<tr>
<td>Hydrocolloids</td>
<td>12%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Alginites</td>
<td>15%</td>
<td>17%</td>
<td>21%</td>
</tr>
<tr>
<td>Others</td>
<td>15%</td>
<td>22%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Discussion and Conclusions

It is vitally important that the delicate newlyformed tissues that appear in wounds undergoing granulation and re-epithelization are protected from trauma. Since the development of tulle gras in the early 20th century there have been many dressing developments for superficial or partial-thickness wounds. Not all of these have been successful as non-adherent and painfree products (Williams, 1996; Schultze et al, 2001).

Table 2. Baseline patients’ characteristics (burns)

<table>
<thead>
<tr>
<th>Patient characteristics</th>
<th>Burns (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (F/M)</td>
<td>45.0%/55.0%</td>
</tr>
<tr>
<td>Age (years)</td>
<td>39.5 (extremes 19–83)</td>
</tr>
<tr>
<td>Body weight (kg)</td>
<td>70.0 (extremes 49–100)</td>
</tr>
<tr>
<td>Delay between burn and first care</td>
<td>2.3 days (extremes 0.5 hours–15 days)</td>
</tr>
<tr>
<td>Wound sites</td>
<td>Number of patients</td>
</tr>
<tr>
<td>Hands</td>
<td>6</td>
</tr>
<tr>
<td>Thorax</td>
<td>2</td>
</tr>
<tr>
<td>Abdomen</td>
<td>1</td>
</tr>
<tr>
<td>Upper limbs</td>
<td>4</td>
</tr>
<tr>
<td>Lower limbs</td>
<td>7</td>
</tr>
</tbody>
</table>
There is a need for a dressing that can remain in place, without adhering, and be painfree and non-traumatic on removal in the treatment of burns, fixation of grafts, abrasions, and chronic wounds. Urgotul® is the first of a new generation of wound dressing, the lipidocolloid dressings. It is an interface (wound contact layer) dressing well designed to treat acute or chronic wounds at their granulation and re-epithelization stages.

This clinical study was aimed at evaluating the tolerability of this new material in various types of wounds and anatomical location. A total of 92 patients were treated over 4 weeks for second-degree burns, acute wounds, and leg ulcers or other chronic wounds. A total of 868 dressing changes were conducted. Ease of dressing application and removal were rated as ‘excellent’ in most of the cases; the dressing did not promote maceration, bleeding or pain. Its conformability to the shape of the wounds was generally good and inappropriate adhesion of the dressing was regarded as a problem in only a single instance.

While this study was not designed to evaluate healing rate, the data collected over a 4-week treatment period are nonetheless encouraging. Urgotul® constitutes a highly promising new generation of dressing which merits further clinical evaluations.

<table>
<thead>
<tr>
<th>Table 3. Patients’ outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Healed before 4 weeks</td>
</tr>
<tr>
<td>4-week study completers</td>
</tr>
<tr>
<td>Drop-outs</td>
</tr>
<tr>
<td>Local adverse event</td>
</tr>
<tr>
<td>Skin grafting</td>
</tr>
<tr>
<td>Wound deterioration</td>
</tr>
<tr>
<td>Osteitis</td>
</tr>
<tr>
<td>Death</td>
</tr>
<tr>
<td>Hospitalization</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 4. Dressing changes: characteristics of Urgotul® in acute or chronic wounds and in burns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Number of documented dressing changes</td>
</tr>
<tr>
<td>Mean wear times (days) (mean and extremes)</td>
</tr>
<tr>
<td>Numbers (%) of changes with the following characteristics</td>
</tr>
<tr>
<td>Very easy or easy dressing application</td>
</tr>
<tr>
<td>Very easy or easy dressing removal</td>
</tr>
<tr>
<td>No pain at dressing removal</td>
</tr>
<tr>
<td>No smell</td>
</tr>
<tr>
<td>No bleeding at dressing removal</td>
</tr>
<tr>
<td>No or minimal maceration</td>
</tr>
<tr>
<td>Very good or good conformability to the wound shape</td>
</tr>
<tr>
<td>No or slight adhesion to the wound</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Table 5. Local adverse events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute wounds</td>
</tr>
<tr>
<td>Pierwound erythema</td>
</tr>
<tr>
<td>Pierwound ulceration</td>
</tr>
<tr>
<td>Overgranulation</td>
</tr>
<tr>
<td>Bleeding</td>
</tr>
<tr>
<td>Pain and inflammatory reaction</td>
</tr>
<tr>
<td>Pain to dressing removal (adhesiveness)</td>
</tr>
</tbody>
</table>

Briggs MN (2000) Topical agents or dressings for pain in venous leg ulcers. Cochrane Database of Systematic Reviews 2: CD001177

This article is reprinted from the British Journal of Nursing, 2002 (Supplement), Vol 11, No 16.

**KEY POINTS**

- Urgotul® is a new lipidocolloid dressing for use on acute and chronic wounds.
- Preliminary clinical trial data show Urgotul® to be safe and effective on partial-thickness burns, and a variety of acute and chronic wounds.
- The combination of hydrocolloid polymers and petrolatum gives the dressing its specific properties and represents an alternative to conventional or modern wound dressings.
- Further comparative clinical trials are underway to establish the relative effects of the Urgotul® dressing on the healing process.

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Description

Interface avec la technologie TRACT, Pansement non-adhésif

DESCRIPTION

L'interface Restore est un pansement non-adhésif, non-adhésif, qui contient des fibrines et des protéines, pour la cicatrisation du tissu cutané.

APPLICATION

- L'interface Restore est destinée à être appliquée sur les plaies cutanées saines ou infestées, sur les plaies chirurgicales ou chirurgicales postopératoires, sur les plaies de pression, sur les plaies de trophées, sur les plaies de voies urinaires, et plus généralement sur toutes les plaies cutanées ou plus profondes.

Précautions

- Éviter de toucher l'interface Restore avec les mains propres ou stériles.
- Éviter de laisser l'interface Restore en contact avec les yeux ou la bouche.
- Éviter de laisser l'interface Restore entrer en contact avec d'autres matériaux, y compris les vêtements ou les objets chimiques.
- Éviter de laisser l'interface Restore en contact avec les matières organiques ou les substances chimiques.
- Éviter de laisser l'interface Restore en contact avec les substances irritantes ou corrosives.

Indications

- L'interface Restore est indiqué pour la cicatrisation des plaies cutanées saines ou infestées, sur les plaies chirurgicales ou chirurgicales postopératoires, sur les plaies de pression, sur les plaies de trophées, sur les plaies de voies urinaires, et plus généralement sur toutes les plaies cutanées ou plus profondes.

Contra-indications

- L'interface Restore n'est pas indiqué pour les plaies qui sont sensibles ou qui sont sujettes à un risque d'infection ou d'inflammation.
- L'interface Restore n'est pas indiqué pour les plaies qui sont sujettes à un risque de sédimentation ou de sécrétion excessive.
- L'interface Restore n'est pas indiqué pour les plaies qui sont sujettes à un risque de croissance excessive.
- L'interface Restore n'est pas indiqué pour les plaies qui sont sujettes à un risque de cicatrisation excessive.

Précautions

- Éviter de laisser l'interface Restore en contact avec les yeux ou la bouche.
- Éviter de laisser l'interface Restore entrer en contact avec d'autres matériaux, y compris les vêtements ou les objets chimiques.
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- Éviter de toucher l'interface Restore avec les mains propres ou stériles.
- Éviter de laisser l'interface Restore en contact avec les yeux ou la bouche.
- Éviter de laisser l'interface Restore entrer en contact avec d'autres matériaux, y compris les vêtements ou les objets chimiques.
- Éviter de laisser l'interface Restore en contact avec les matières organiques ou les substances chimiques.
- Éviter de laisser l'interface Restore en contact avec les substances irritantes ou corrosives.

Intructions de mise en place

- Nettoyer les plaies à l'eau tiède savonneuse et les sécher au seau.
- Appliquer une couche de coton humide sur la plaie.
- Appliquer l'interface Restore sur la couche de coton humide.
- Couvrir l'interface Restore avec un bandage stérile.

Précautions

- Éviter de toucher l'interface Restore avec les mains propres ou stériles.
- Éviter de laisser l'interface Restore en contact avec les yeux ou la bouche.
- Éviter de laisser l'interface Restore entrer en contact avec d'autres matériaux, y compris les vêtements ou les objets chimiques.
- Éviter de laisser l'interface Restore en contact avec les matières organiques ou les substances chimiques.
- Éviter de laisser l'interface Restore en contact avec les substances irritantes ou corrosives.

Contra-indications

- L'interface Restore n'est pas indiqué pour les plaies qui sont sensibles ou qui sont sujettes à un risque d'infection ou d'inflammation.
- L'interface Restore n'est pas indiqué pour les plaies qui sont sujettes à un risque de sédimentation ou de sécrétion excessive.
- L'interface Restore n'est pas indiqué pour les plaies qui sont sujettes à un risque de croissance excessive.
- L'interface Restore n'est pas indiqué pour les plaies qui sont sujettes à un risque de cicatrisation excessive.

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Restore Contact Layer with TRIACT technology, Non-Adherent Dressing

DESCRIPTION
Restore Contact Layer is a non-adherent, non-adherent wound contact dressing composed of a polymeric mesh impregnated with a matrix consisting of hyaluronic acid and sodium hyaluronate. It provides a moist environment that promotes healing.

INDICATIONS FOR USE
Restore Contact Layer is indicated in the treatment of wounds, ulcers, burns, and other skin conditions. It is particularly beneficial for wounds with high bacterial counts and for patients with diabetes or chronic wounds.

MECHANISM OF ACTION
The hydrogel matrix of the Restore Contact Layer provides a moist environment that promotes wound healing by maintaining the optimal moisture levels necessary for the healing process.

APPLICATION
1. Clean the wound area with an appropriate wound cleanser.
2. Gently remove any debris or exudate from the wound.
3. Apply a thin layer of Restore Contact Layer over the wound area.
4. Cover the Restore Contact Layer with a non-adherent dressing or bandage.

PRECAUTIONS
- Use Restore Contact Layer as directed.
- Avoid applying too much pressure on the dressing.
- Do not use on areas with high bacterial counts.

STORAGE
Store Restore Contact Layer in a cool, dry place.

Available in various sizes and quantities.

Technical Inquiry:
For further information, please contact our customer service at 1-800-CALL-RESTORE.

- Restore Incorporated
- 123 Main Street
- Anytown, USA 12345

- E-mail: info@Restore.com
- Website: www.Restore.com

Restore Interface with the Technology TRIACT, Pansement non-adhésif

DESCRIPTION
L'interface Restore est un pansement non-adhésif, non-adhésif constitué d'une fine lame polymère imperméable de particules hyaluroniques (polysaccharides), de physiologie et de conformité.

INDICATIONS
L’interface Restore est indiquée dans le traitement des lésions cutanées chroniques, notamment pour les cicatrisations cutanées, les plaies de lèvre, les ulcérations et les plaies de décubitus.

MISES EN GARDE ET PRÉCAUTIONS D’EMPLOI
- L'interface Restore n'est pas indiquée pour les plaies infectées ou contaminées.
- Avant l'application, l'interface Restore doit être bien nettoyée et débarrassée de toute graisse ou poudre.
- En cas d'infection ou de suppuration, l'interface Restore ne doit pas être utilisée.

CONTRE-INDICATIONS
- Les patients qui souffrent d'une allergies à l'un des ingrédients de l'interface Restore ne doivent pas l'utiliser.

PRESERVATION
- L'interface Restore est disponible dans des formats de 5 mm (0,25 cm x 10 cm) et 8 mm (0,35 cm x 10 cm).
- Chaque boîte contient 10 interfaces.

STOCKAGE
- Stocker à l'abri de la lumière et à une température comprise entre 15 et 30°C.

DIRECTIONS FOR USE
- Nettoyer la plaie avec une solution saline, puis appliquer l'interface Restore sur la plaie.
- Couvrir l'interface Restore avec une couche de pansement non-adhésif.
- Vérifier la couche de pansement après 24 heures pour s'assurer qu'elle est toujours adéquate.

INSTRUCTIONS D’EMPLOI
- Éviter de se blesser ou de subir une blessure sur la plaie.
- Ne pas retirer la couche de pansement avant 24 heures.
- En cas d’infection ou de suppuration, consulter un professionnel de la santé.

INFORMATION
- Pour plus d'informations, consulter le site web de Restore Incorporated ou contacter nos services de soutien au 1-800-CALL-RESTORE.

Technical Inquiry:
Restore Incorporated
123 Main Street
Anytown, USA 12345

- E-mail: info@Restore.com
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