Evaluation of healing of pressure ulcers through thermography: a preliminary study

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Abstract

Introduction: Thermography is a surface thermal radiation measurement technique whose application has been expanding in the healthcare field. The unhealed wound is a serious public health problem because it intervenes in the quality of life of patients and may cause emotional and psychological losses. The wound temperature can provide quantitative data that allow for the healing process to be monitored. The aim of this study was to verify whether thermography can be used as a method to evaluate the healing of pressure ulcers.

Methods: Eight participants with sacral pressure ulcers were recruited and randomly divided into two groups: A (control) and B (experimental). Both groups received standard treatment for a period of four weeks, which consisted of a daily cleaning of the pressure ulcers with physiological saline (sodium chloride 0.9%) followed by an alginate hydrogel dressing. The group B received light-emitting diode (LED) phototherapy in addition to standard treatment, three times a week, yielding a total of 12 sessions. Photographs and thermograms of each pressure ulcer were obtained in all sessions in both groups.

Results: Pressure ulcers treated with LED phototherapy were healed. The pressure ulcer area of group B decreased over the 12 treatment sessions, whereas the pressure ulcer area of group A increased. The ulcer temperature of group B was higher than that of group A during the treatment (temperature difference up to 7.6%).

Discussion: The present study suggests a relationship between the temperature and area of pressure ulcers and proposes thermography as an adjunctive method for the evaluation of healing processes.

Keywords: Thermography, Wound healing, Pressure ulcer.

Introduction

Thermography is a measurement technique that quantifies body surface temperature by capturing the thermal radiation emitted by the body and thereby produces a digital image. The captured radiation is converted to an electrical signal, forming an image in which the results are expressed in gray levels or in color. The thermogram shows a distribution of colors on the surface of a body, allowing for the evaluation and quantification of temperature (Calado et al., 2014).

This technique is an objective method for identifying objects that are not illuminated and diagnose structures and industrial equipment based on the surface temperature of structures in the analyzed environments (Andrade and Eduardo, 2011). Moreover, studies show that thermography has been expanding in the healthcare field in recent years. The technique is a safe, effective and reliable method for the examination of the human body. The advantages of this technique are that it is noninvasive, it is a quick method for diagnosing diseases, no patient contact is required, it does not inflict any pain, it does not require the use of contrasts and it is inexpensive. The equipment is portable, and the information is available in real time (Bronzino, 2006; Yamamoto et al., 2013).

Currently, thermography is used in many specialized healthcare fields, including oncology (Zore et al., 2013), rheumatology (Frize and Ogungbemile, 2012), orthopedics (Haddad et al., 2012), neonatal medicine (Abbas et al., 2011) and neurology (Saito et al., 2000). Thermography has been used to monitor pain (Bostock et al., 2005), inflammation (Christensen et al., 2012), respiratory disease (Rich et al., 2004), vascular diseases (Huang et al., 2011) and wound healing (Nagase et al., 2011; Nakagami et al., 2010).

Healing is crucial to the survival and quality of life of humans and animals (Vermolen and Javierre, 2010). It is a complex process, and there are numerous factors, local or systemic, that can interfere with tissue repair, resulting in delays, in poor aesthetic appearance and in increased morbidity and mortality of patients (Perricone, 1999; Young and McNaught, 2011).

According to the literature, the population is subject to ulceration, with an increased prevalence among elderly people (Skene et al., 1992). In the United
States, it is estimated that 1.3 million to 3 million adults have a pressure ulcer, with an estimated cost of $500 to $40,000 required to heal each ulcer (Lyder, 2003). In Brazil, statistical data about the incidence and prevalence of chronic wounds and public spending are rare in the literature. However, the care of patients with such conditions is quite common in dermatology, vascular medicine, plastic surgery and physiotherapy services (Datasus, 2012). Thus, the unhealed wound represents a serious public health problem.

It has been shown that physical conditions such as diabetes mellitus, obesity, malnutrition, old age (over 60), decreased perfusion, malignancy, organ failure, sepsis, and even restrictions in mobility have an impact on healing. Furthermore, wound-related factors such as ulcer size (over 2 cm²), duration (over two months) and ulcer depth (penetration through to exposed tendon, ligament, bone or joint) are the most important factors for predicting patient outcomes (European..., 2008). Studies have also shown that the probability of healing increases with a decrease in the size and depth of pressure ulcers (Kramer and Kearney, 2000).

According to International EPUAP-NPUAP (European... 2009), pressure ulcers are classified into four categories. Category I: intact skin with non-blanchable erythema of a localized area usually over a bony prominence. Discoloration of the skin, warmth, edema, hardness or pain may also be present. Darkly pigmented skin may not show visible blanching. Category II: partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. The ulcer may also present as an intact or open/ruptured serum-filled or serosanguinous filled blister. Category III: full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Some slough may be present. The ulcer may also show undermining and tunneling. Category IV: full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. The ulcer often shows undermining and tunneling.

The most reliable indicator of healing is the percentage of wound area reduction, which refers to the diminishment of wound area relative to that measured on day zero (Robson et al., 2000). However, this approach requires longitudinal observation (Nakagami et al., 2010). Real-time evaluation is necessary to identify and monitor the healing results of a treatment (Nakagami et al., 2010). However, it is difficult to precisely quantify wound healing.

Based on literature findings, the measured temperature of a wound could be an indicator of wound healing (Garcia and Siddiqui, 2012; Kateb et al., Nakagami et al., 2010; Sayre et al., Yamamoto et al., 2013). According to Rocha (2009), there is an optimum temperature range for healing to occur such that temperatures outside this range may lead to a delay in the healing process.

The present study aims to verify whether thermography can be used as a method for evaluating the healing of pressure ulcers.

Methods

Study design

This study protocol was approved by the Research Ethics Committee, Universidade Federal de Minas Gerais (UFMG), Belo Horizonte, Brazil (approval No. CAAE 0411082600005149).

Participants were recruited between September and December 2013 at a hospital in Belo Horizonte, Brazil. The inclusion criteria were pressure ulcers located in the sacral region, without clinical signs of infection, and ages between 40 and 80 years. Sacral pressure ulcers were chosen because of the high incidence of these wounds in the hospital.

The exclusion criteria were diabetes, development of infection during treatment, pregnancy, presence of cancer, photosensitivity or any adverse reactions under exposure to sunlight.

Protocol

The participants who met the inclusion criteria were randomly divided into two groups: A (control) and B (experimental). Identification tags corresponding to group A or B were placed in sealed unmarked envelopes and shuffled. The number of envelopes was the same for both groups. With each new participant who entered the study, an envelope was randomly selected and opened, with the participant being duly assigned to either group A or B. The standard treatment was applied in groups A and B. Light-emitting diode (LED) phototherapy alone was used in group B.

The standard treatment consisted of a daily cleaning of the pressure ulcers with physiological saline (sodium chloride 0.9%) followed by an alginate hydrogel dressing over a period of 4 weeks.

LED phototherapy was applied through a prototype featuring a cluster of 60 LED lights (30 red and 30 infrared) arranged in concentric circles. The prototype was developed by the company SEVA Electronic Engineering. The parameters used were wavelengths of 660 and 940 nm, continuous emission mode and an irradiation dose of 4 J/cm². The prototype was controlled by a software program that estimated the time of application based on the selected dose. The phototherapy was applied three times a week over a period of four weeks, yielding 12 sessions
for each participant. The parameters selected for the prototype were based on a literature review concerning the biological effects (Agnol et al., 2009; Lanzafame et al., 2007; Tada et al., 2009) of LED phototherapy on wound healing.

**Evaluation of pressure ulcers area**

Photographs of each pressure ulcer were captured three times a week over 12 sessions using a Nikon® D5100 camera with an 18-55 mm lens. A Vernier Caliper® with a measuring range of 0-150 mm was used to measure each ulcer. The digital images were analyzed by the software program Quantikov, version 8.12, which calculated the pressure ulcer area.

**Thermographic evaluation**

Thermograms of each pressure ulcer were obtained three times a week over 12 sessions. A FLIR I60® thermographic camera with a 180 × 180 pixel IR resolution, a spectral range of 7.5 to 13 µm and a thermal sensitivity < 0.1 °C at 25 °C was used for thermographic evaluation.

The thermograms were captured after removing the dressing before the standard treatment or application of phototherapy. Each participant was placed in the lateral decubitus position, and the thermographic camera was positioned perpendicular to the pressure ulcer at a distance of 15 or 20 cm depending on the pressure ulcer size.

The ambient temperature and relative humidity were previously measured using a FLUKE® 971 digital hygrometer with a precision of ± 0.5 °C. The reflected average temperature was considered equal to ambient temperature. The emissivity value adopted was similar to the dermis emissivity value (0.98) reported in the literature (Bernard et al., 2013).

**Uncertainty analysis**

The calculations of the temperature presented in this study were initially performed by the software FLIR Therma CAM Researcher to obtain the coordinates of a given point. This point was selected to be in the center of the pressure ulcer, disregarding regions of moisture. The FLIR Therma CAM Researcher exported a file .mat for the software Thermography Measurement Uncertainty developed in MATLAB (Teixeira, 2012).

This program was a systematized routine calculation according to the GUM (Guide to the Expression of Uncertainty in Measurement) method, which should be proportional to the array of radiation signals and analyzes the uncertainty of the temperature measurement, taking the coordinates of the measurement point, the distance, the ambient temperature, the reflected average temperature and emissivity of the skin as input (Table 1).

**Results**

The sample of this study consisted of eight participants with a sacral pressure ulcer, who were divided into two groups according to the type of treatment: A (control) and B (experimental). The clinical characteristics of both groups of participants, such as age, ulcer classification, duration of ulcer and initial ulcer size, are presented in Table 2.

| Parameter              | Uncertainty | Assumed distribution |
|------------------------|-------------|----------------------|
| Emissivity             | ± 0.01      | Rectangular          |
| Temperature            | ± 0.5 °C    | Rectangular          |
| Average temperature reflected | ± 0.5 °C  | Rectangular          |
| Distance               | ± 0.01 m    | Rectangular          |

| Table 1. Values of uncertainty of input data. |

| Characteristic | Group A         | Group B         |
|----------------|-----------------|-----------------|
| Number of participants | 4               | 4               |
| Age in years (mean ± SD) | 60.8 ± 21.1     | 60.3 ± 15.3     |
| Range          | 41 – 80         | 40 – 77         |
| Ulcer classification |                 |                 |
| Category I     | 0%              | 0%              |
| Category II    | 50%             | 25%             |
| Category III   | 25%             | 50%             |
| Category IV    | 25%             | 25%             |
| Duration of ulcer in months (mean ± SD) | 20.3 ± 20.8     | 10.3 ± 9.7      |
| Range (months) | 2 – 48          | 2 – 24          |
| Initial ulcer size in cm² (mean ± SD) | 52.3 ± 16.1     | 55.7 ± 13.7     |
| Range (cm²)    | 35.2 – 71.3     | 44.8 – 73.3     |

| Table 2. Clinical characteristics of the participants. |
In this study, Table 2 shows that the factors age and initial ulcer size were similar between the two groups of participants. There were small differences between groups A and B with respect to ulcer classification and duration of ulcer, which can be justified by randomization.

Figure 1 shows the evolution of pressure ulcers in both groups, specifically in sessions 1, 6 and 12. Figures 1a, 1b, and 1c represent a participant from group A, whereas Figures 1d, 1e, and 1f represent a participant from group B. It can be observed that the pressure ulcer of the participant from group A increased in area and depth in the 6th session (Figure 1b). In addition, the depth increased further in the 12th session (Figure 1c). The pressure ulcer of the participant from group B showed an improvement with respect to local irrigation, the formation of granulation tissue and reduction in area in the 6th (Figure 1e) and 12th session (Figure 1f).

Figure 2 represents the difference between the measured ulcer area in the initial session and that measured in the final session for both groups. For group A, there was an increase between the area at the beginning and at the end of the intervention period. For group B, the area at the end of the treatment was smaller than that at the beginning.

Figure 3 shows the evolution of pressure ulcers in groups A and B over the 12 treatment sessions. The pressure ulcer area in group A increased, whereas the pressure ulcer area in group B decreased.

Figure 4 shows the temperature of pressure ulcers in groups A and B over the 12 treatment sessions. The uncertainty in the temperature measurements was ±1 °C. Participants from both groups presented ulcer temperatures within the appropriate range for healing. According to Rocha (2009), the appropriate temperature for healing occurs between 32 °C to 36 °C.

Figure 5 shows the percentage difference in temperature of pressure ulcers between group B and group A. The trend line indicates that the percentage difference between groups A and B increased with the number of sessions. The temperature difference between groups B and A ranged from 1.9% to 7.6% during the treatment.

**Discussion**

The healing of pressure ulcers treated with LED phototherapy and alginate hydrogel dressing (group B) cannot be attributed to possible differences in the clinical characteristics of participants because the two groups had similar characteristics (Table 2). Moreover,
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the same inclusion and exclusion criteria were used to admit both groups of participants into the study.

Figure 1 shows differences between participants in the two groups. The participant from group B showed an improvement in local irrigation, formation of granulation tissue and reduction in area. Furthermore, in comparing the last session to the initial session, all participants in group B showed a reduction in pressure ulcer area, unlike the participants in group A, who showed an increase in pressure ulcer area (Figure 2). Similar results have been observed in other studies (Caetano et al., 2009; Erdle et al., 2008; Minatel et al., 2009; Whelan et al., 2003;)

Group B showed a reduction in area over the course of the treatment period, whereas group A did not (Figure 3). The discrepancy may be explained by the fact that group B received phototherapy in addition to the standard treatment.

Our results are in accord with those reported in other studies in the literature, which indicate that LED phototherapy promotes wound healing due to the physiological effects of phototherapy, such as stimulation of ATP synthesis, increased fibroblast proliferation, collagen production and stimulation of angiogenesis (Corazza et al., 2007; Karu, 2003; Sousa et al., 2010).

The results of our study also indicate that the temperature of pressure ulcers was within the appropriate range for healing (32° - 36 °C) in both groups (Figure 4). All cellular functions are affected by temperature, including chemical reactions (metabolism, protein synthesis and oxidation) and phagocytosis, mitosis and locomotion (Bryant and Nix, 2012).

However, when comparing the two groups, group A demonstrated a lower pressure ulcer temperature (32-33 °C) than did group B (34-35 °C) during the treatment. The difference in temperature between the two groups reached up to 7.6% (Figure 5).

Analysis of the results revealed that participants in group A showed an increase in wound area and a low pressure ulcer temperature, whereas those in group B showed a decrease in wound area and a high pressure ulcer temperature. This observation suggests a relationship between the wound area and temperature of pressure ulcers.

It should be noted that this study was limited by its small sample size and the lack of studies about thermography and wound healing. However, the results of this study suggest a relationship between area and temperature variations of pressure ulcers. Therefore, thermography may be considered a suitable adjunctive method for the evaluation of the wound healing process.

In future studies, we suggest verifying the validity of the findings presented herein, applying the methodology to a larger number of participants. We also suggest executing the protocol in another anatomical region or on another type of wound, e.g., venous ulcers, and observing whether there are significant changes in temperature.

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