How to order

Pack size:
Kerraboot® is available on prescription in four sizes and two variants, opaque ‘White’ and transparent ‘Clear’. Kerraboot® is packed in individual sterile pouches. There are 10 pouches in a box. Minimum order quantity is one box. Kerraboot® is available at all retail pharmacists and to add to your convenience we have made Kerraboot® available through Script Easy.

Script Easy contact details:
Freephone: 0800 1077 107
Fax: 01565 65411

Further information:
Should you require any specific product information or advice please call your local Clinical Sales Specialist or contact our customer care team:
Tel: +44 (0)1565 654920     E-mail us at: kerraboot@woundcaresolutions.co.uk        www.kerraboot.com

<table>
<thead>
<tr>
<th>Unit Size</th>
<th>Extra-Small</th>
<th>Small</th>
<th>Large</th>
<th>Extra-Large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoe Size</td>
<td>up to 3</td>
<td>4-7</td>
<td>7+</td>
<td>7+</td>
</tr>
<tr>
<td>Pack size</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Overall length</td>
<td>460mm</td>
<td>460mm</td>
<td>536mm</td>
<td>536mm</td>
</tr>
<tr>
<td>Base of heel to tip of foot</td>
<td>271mm</td>
<td>313mm</td>
<td>362mm</td>
<td>362mm</td>
</tr>
<tr>
<td>Circumference of padded top</td>
<td>444mm</td>
<td>444mm</td>
<td>527mm</td>
<td>650mm</td>
</tr>
<tr>
<td>PIP Code for Clear</td>
<td>3260221</td>
<td>3013497</td>
<td>3013505</td>
<td>3260239</td>
</tr>
<tr>
<td>PIP Code for White</td>
<td>3260270</td>
<td>3223989</td>
<td>3223997</td>
<td>3260247</td>
</tr>
<tr>
<td>NHS Cat Number for Clear</td>
<td>ELZ093</td>
<td>ELZ003</td>
<td>ELZ004</td>
<td>ELZ094</td>
</tr>
<tr>
<td>NHS Cat Number for White</td>
<td>ELZ103</td>
<td>ELZ088</td>
<td>ELZ089</td>
<td>ELZ101</td>
</tr>
</tbody>
</table>

Kerraboot® is a registered trademark of Crawford Healthcare Limited. © Copyright Crawford Healthcare Limited, 2011.
Debridement of lower limb wounds

References

Before

Pressure ulcer on heel

Lower limb salvage

Grade IV pressure ulcer

Forefoot amputation due to ischaemia

Elderly female admitted to residential care with reduced mobility. Small blister on left heel did not respond to treatment. Within 3 months, the skin had become macerated, and the wound, which now measured 6 x 5.5cm, become sloughy and necrotic.

Elderly female patient with Type 1 Diabetes and lower limb ischaemia. Assigned an unfit for vascular intervention and below knee amputation recommended, rejected by family.

A grade IV pressure ulcer on the right heel. Measuring 7 x 4cm with 80% necrotic tissue and 20% slough. The slough consistency ranged from thick and tenacious to a semi-liquid, highly odorous, purulent discharge. The wound edge and surrounding tissue was very discoloured and oedematous.

This patient was admitted for amputation of toes due to ischaemia. Two weeks post surgery, the wound required further debridement. TNP was subsequently applied but the patient was unable to tolerate TNP. Kerraboot® was then initiated which was changed daily. The patient was involved in his own wound care. On initiating Kerraboot® treatment the amputation site was macerated, and had 95% thick green slough.

After

Using Kerraboot® facilitated autolysis after 4 weeks. Pain and frequency of dressing changes were reduced and leakage stopped. Most importantly the wounds responded remarkably well to this treatment removing the need for amputation.

After 7 weeks of Kerraboot® treatment, the wound measured 5 x 3cm. It had minimal slough with over 80% granulation. The exudate level was minimal and of a serous nature. The peri-wound skin was in good condition with a capillary refill time of less than 2 seconds.

After 2 weeks of Kerraboot® treatment the surrounding skin had greatly improved, the amputation site had more granulation tissue and the layer of slough had significantly decreased. The use of Kerraboot® had benefits for the patient including reduced pain on dressing change, reduced odour, and the dressing could be applied by the patient.

After treating with Kerraboot® daily for the first 10 days the wound looked much healthier with black necrotic material removed. The wound edges were looking healthy.

After 7 weeks of Kerraboot® treatment, the wound measured 5 x 3cm. It had minimal slough with over 80% granulation. The exudate level was minimal and of a serous nature. The peri-wound skin was in good condition with a capillary refill time of less than 2 seconds.

After 2 weeks of Kerraboot® treatment the surrounding skin had greatly improved, the amputation site had more granulation tissue and the layer of slough had significantly decreased. The use of Kerraboot® had benefits for the patient including reduced pain on dressing change, reduced odour, and the dressing could be applied by the patient.

After

Elderly female admitted to residential care with reduced mobility. Small blister on left heel did not respond to treatment. Within 3 months, the skin had become macerated, and the wound, which now measured 6 x 5.5cm, become sloughy and necrotic.

Elderly female patient with Type 1 Diabetes and lower limb ischaemia. Assigned an unfit for vascular intervention and below knee amputation recommended, rejected by family.

A grade IV pressure ulcer on the right heel. Measuring 7 x 4cm with 80% necrotic tissue and 20% slough. The slough consistency ranged from thick and tenacious to a semi-liquid, highly odorous, purulent discharge. The wound edge and surrounding tissue was very discoloured and oedematous.

This patient was admitted for amputation of toes due to ischaemia. Two weeks post surgery, the wound required further debridement. TNP was subsequently applied but the patient was unable to tolerate TNP. Kerraboot® was then initiated which was changed daily. The patient was involved in his own wound care. On initiating Kerraboot® treatment the amputation site was macerated, and had 95% thick green slough.

After treating with Kerraboot® daily for the first 10 days the wound looked much healthier with black necrotic material removed. The wound edges were looking healthy.

Using Kerraboot® facilitated autolysis after 4 weeks. Pain and frequency of dressing changes were reduced and leakage stopped. Most importantly the wounds responded remarkably well to this treatment removing the need for amputation.

After 7 weeks of Kerraboot® treatment, the wound measured 5 x 3cm. It had minimal slough with over 80% granulation. The exudate level was minimal and of a serous nature. The peri-wound skin was in good condition with a capillary refill time of less than 2 seconds.

After 2 weeks of Kerraboot® treatment the surrounding skin had greatly improved, the amputation site had more granulation tissue and the layer of slough had significantly decreased. The use of Kerraboot® had benefits for the patient including reduced pain on dressing change, reduced odour, and the dressing could be applied by the patient.

After

Elderly female admitted to residential care with reduced mobility. Small blister on left heel did not respond to treatment. Within 3 months, the skin had become macerated, and the wound, which now measured 6 x 5.5cm, become sloughy and necrotic.

Elderly female patient with Type 1 Diabetes and lower limb ischaemia. Assigned an unfit for vascular intervention and below knee amputation recommended, rejected by family.

A grade IV pressure ulcer on the right heel. Measuring 7 x 4cm with 80% necrotic tissue and 20% slough. The slough consistency ranged from thick and tenacious to a semi-liquid, highly odorous, purulent discharge. The wound edge and surrounding tissue was very discoloured and oedematous.

This patient was admitted for amputation of toes due to ischaemia. Two weeks post surgery, the wound required further debridement. TNP was subsequently applied but the patient was unable to tolerate TNP. Kerraboot® was then initiated which was changed daily. The patient was involved in his own wound care. On initiating Kerraboot® treatment the amputation site was macerated, and had 95% thick green slough.

After treating with Kerraboot® daily for the first 10 days the wound looked much healthier with black necrotic material removed. The wound edges were looking healthy.

Using Kerraboot® facilitated autolysis after 4 weeks. Pain and frequency of dressing changes were reduced and leakage stopped. Most importantly the wounds responded remarkably well to this treatment removing the need for amputation.

After 7 weeks of Kerraboot® treatment, the wound measured 5 x 3cm. It had minimal slough with over 80% granulation. The exudate level was minimal and of a serous nature. The peri-wound skin was in good condition with a capillary refill time of less than 2 seconds.

After 2 weeks of Kerraboot® treatment the surrounding skin had greatly improved, the amputation site had more granulation tissue and the layer of slough had significantly decreased. The use of Kerraboot® had benefits for the patient including reduced pain on dressing change, reduced odour, and the dressing could be applied by the patient.