

# TREATMENT OF CHRONIC WOUNDS WITH ALKALISED FRUIT EXTRACT: CASE SERIES

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## Introduction

- OPAL alkalised fruit extract has been developed to treat chronic wounds of various aetiologies
- Patients with chronic non-healing wounds are at increased risk of serious complications such as septicaemia and osteomyelitis
- Case studies are presented of seven participants with chronic wounds that failed best practice treatments prior to application of OPAL products

## Methods

- OPAL products are made by adding sodium bicarbonate to heated fruit pulp
- OPAL 001 products made from mixed fruit pulp and OPAL A products made from paw paw pulp were used as filtrate (100%) and cream formulation (30% w/w filtrate in aqueous cream base)
- The OPAL treatment regimen involved daily application of the undiluted filtrate directly into the wound and application of cream to the surrounding skin, prior to application of non-impregnated dressings
- Case reports were compiled from the clinical and photographic records of participants treated with OPAL products between 2007 and 2009

## Case Studies

Six of seven participants experienced healing of chronic wounds previously resistant to best practice therapies. One participant failed to respond and underwent further surgical intervention. This was the only reported adverse finding during OPAL use.

### Case 1

**17 year old female, non-healing post-surgical pilonidal sinus wound**

**Aug 2007:** initial excision chronic pilonidal sinus; in **12 months** four plastic surgeries failed

**25 Aug 2008:** commenced daily treatment with **OPAL A** filtrate and cream



- Week 10:** new skin formation with active closure
- Week 25:** wound fully healed and remained intact 12 months later

### Case 2

**63 year old male, IDDM, non-healing right below knee amputation stump**

**Apr 2008:** RBKA stump failed to heal for eight months due to ischaemia and infection central area

**Dec 2008:** non-viable skin, end of stump raw with accumulation of white, necrotic tissue

**14 Dec 2008:** commenced daily application of **OPAL 001** filtrate and cream



- Week 2:** non-viable skin well defined and localised, surrounding skin appeared healthy
- Week 4:** necrotic skin almost peeled away leaving healthy skin, ulcer almost healed

### Case 3

**87 year old male, asthma and COPD, in residential care**

**Mar 2009:** fall, lower leg skin tears; became infected, painful over three months

**30 Jun 2009:** commenced daily **OPAL A** filtrate and cream



- Week 4:** smaller, the necrotic material cleared from distal ulcer, marked reduction in slough
- Week 8:** wounds almost completely healed. Remained healed at 20 weeks

### Case 4

**89 year old female, Alzheimer's, hypertension, brain stem CVA, chest oedema, in residential care**

**20 Jul 2008:** skin tears right lower calf; sloughy and inflamed despite best practice management

**3 Aug 2008:** commenced daily treatment with **OPAL 001**; shallow ulcer, exudate, haemoserous ooze

- Week 3:** wound completely healed

## Conclusions

- Clinical experience in six of seven participants suggests a strong temporal relationship between OPAL products and healing of chronic wounds unresponsive to standard therapies
- Mechanisms of action and safety of OPAL products require further investigation

### Acknowledgements

OPAL products were produced and supplied by Phoenix Eagle Company Pty Ltd; Poster design by Deborah Taylor, Marinella Messina and Lyn Tozer, Datapharm Australia Pty Ltd

### Case 5

**71 year old male, above left knee amputee, phantom limb pain, NIDDM, arteriopathy**

**Sep 2008:** ulcer on bunion of right great toe, commenced antibiotics but remained unresponsive to best practice management for 11 months; extremely painful requiring opiate analgesia

**11 Aug 2009:** ulcer unhealed and painful; commenced daily treatment with **OPAL A** filtrate and cream



- Week 2:** clean, surrounding skin hyperaemic
- Week 4:** clean and dry with significantly reduced pain
- Week 16:** ulcer completely healed

### Case 6

**80 year old male, thromboangiitis obliterans, bilateral peripheral vascular insufficiency**

**May 2008:** painful left foot, both feet appeared ischaemic

**17 Jun:** left 4<sup>th</sup> toenail removed, grossly infected, hospitalised with cellulitis; failed to heal

**9 Dec 08:** commenced treatment with **OPAL A** filtrate and cream

**18 Dec 08:** ulcer drier, toe less swollen

**19 Dec 08:** the toe became necrotic and was subsequently amputated. The surgical wound failed to heal for two months and left BKA performed.

### Case 7

**87 year old female, multiple extensive CVAs, generalised arteriopathy, PVD, in residential care**

**Feb 2007:** right 2<sup>nd</sup> toe ulcer infected, deteriorated over 10 months

**29 Nov 2007:** commenced **OPAL 001** filtrate and cream



- Week 12:** ulcer clean, oedema and redness abated over next three weeks
- Week 27:** healed with improved colour and condition of surrounding skin

**May 2008:** left 2<sup>nd</sup> toe ulcer, deteriorated due to cold-induced vasoconstriction

**15 May 2008:** commenced **OPAL 001**, healed **Week 4**, improved colour, condition of surrounding skin

In mid-2008 **OPAL 001** was also applied to a failed skin graft (post-excision SCC) on her left temple which healed with minimal scarring after 12 weeks of treatment

