

Wound Compendium

Octenidine. Trusted by Science.
Chosen for Healing.



we protect lives
worldwide

Table of content

01	Holistic approaches in wound management: Clinical excellence meets person-centred care	5
02	Different types of wounds: Main definitions and clinical classifications	6
	Acute wounds	6
	Chronic wounds	7
03	The science of wound healing: Key definitions and processes	10
	Classification and pathophysiology of wound healing	10
	Factors influencing wound healing	12
04	Octenidine: Trusted performance driven by innovation	14
	Non-specific mode of action	15
	Rapid and effective against clinically relevant emerging pathogens	16
	Effective against (poly)microbial biofilms	17
	Long-term residual effect	17
	High biocompatibility index	18
	No cytotoxic effects on human skin cells	18
	Anti-inflammatory and protease-inhibiting properties	19
	Improved scar quality	20
	Promotion of wound healing and cost efficiency	20
05	Octenidine-based product portfolio: Antisepsis for improved wound healing	21
	Comprehensive wound care solutions	22
	Optimal wound care workflow	23
06	Effective mechanical debridement: schülke wound pads	24
07	Protection and intensive care for irritated skin: octenisept® protect & repair cream	25
08	schülke: Your trusted partner in advanced wound care	26
09	Translating scientific evidence into practice: Clinical case reports	27
10	References	51



Access the digital edition of the
schülke Wound Compendium.

Octenidine by schülke: The success story of an active substance

In the course of pursuing a novel antiseptic agent, octenidine was first synthesised over 35 years ago as part of our in-house research efforts. Following comprehensive preclinical and clinical investigations, octenisept® was approved in 1990 as the first mucous membrane antiseptic containing octenidine. In the following years, the market authorisation was expanded to further include antiseptic wound care.

By now, octenisept® has become a well-established medicinal product characterised by a broad spectrum of antimicrobial efficacy and an excellent safety profile. Its clinical applications are manifold and extend across a number of medical specialties, including professional wound management, gynaecology, intensive care medicine and perioperative settings. Moreover, the availability of octenisept® through pharmacies without prescription has facilitated its widespread use in home-based first-aid practices for minor injuries.

A brief look back: Following its initial approval in 1990, octenisept® emerged as an innovative alternative to the widely used PVP-iodine-based products of that time. Beyond its favourable tolerability and efficacy profile, octenisept® rapidly gained the trust of healthcare professionals due to its colourless formulation – an essential attribute in facilitating unobstructed visual assessment of wound healing. Though initially new, octenisept® offered meaningful benefits for both clinicians and patients alike. Today, more than three decades later, octenisept® is widely recognised as a benchmark in modern wound management, holding a leading market position in the antiseptics of wounds and mucosal

tissues across numerous European countries, as well as in parts of Asia and Australia.

The requirements for the local treatment of acute and chronic wounds are often highly diverse and complex. In recent years, the octenidine-based product portfolio centred around octenisept® has been continuously expanded and refined in close collaboration with international experts from multiple medical disciplines. Today, we offer targeted solutions for every phase of wound healing and for specific wound conditions, aligned with a holistic therapeutic approach.

Our primary objective is to support both people with a wide variety of different wounds as well as healthcare professionals with innovative, evidence-based treatment options that perfectly integrate into their daily routine. Alongside excellent tolerability and ease of use, we place the highest standards on demonstrating clinical effectiveness in modern wound care. All octenidine-based products are developed with strong practical relevance and in accordance with the current state of scientific evidence. **We are fully committed to improving the quality of life of affected individuals.**

01 Holistic approaches in wound management: Clinical excellence meets person-centred care

Voltaire, one of the most influential writers of the Enlightenment, once remarked that “time heals all wounds”. A notion that – while philosophically resonant – does not consistently hold true in clinical reality, where even a minor injury can turn into a chronic wound.

The prevalence of both acute and chronic wounds is increasing every year, driven by an ageing population and the growing incidence of wound-related comorbidities, and remains a continuous concern of health systems worldwide. Addressing this challenge requires accurate diagnosis, the establishment of effective treatment strategies and the careful selection of appropriate wound care products to maximise healing outcome while minimising economic burden.

Professional wound management usually starts throughout an accurate assessment of the patient’s overall clinical condition. A comprehensive understanding of the individual’s health status, general skin integrity and the nature and condition of the wound are crucial to optimise therapeutic outcomes and to reduce the risk of complications or delayed healing. One of the key objectives is to support the body’s natural self-healing power as effectively as possible. This requires a deep understanding of the physiology of wound healing and the application of individualised treatment strategies based on the latest scientific evidence. In this context, **interdisciplinary collaboration across medical**

specialties is increasingly recognised as a critical factor in advancing the quality of wound care – simultaneously improving patient outcomes and reducing healthcare costs.

Moreover, international associations increasingly advocate the concept of **person-centred care (PCC)** as a key holistic approach to improve healing outcomes.¹⁻³ PCC recognises patients’ perspectives, beliefs and autonomy focusing on the individual as a whole rather than on disease patterns alone. Moreover, this model emphasises an **active cooperation between people and healthcare professionals**, promoting shared decision-making, active engagement in self-care and mutual respect. By fostering strong, collaborative relationships, PCC has been shown to enhance treatment adherence, clinical healing outcomes, patient satisfaction and the overall quality of care. However, despite the growing body of scientific evidence supporting PCC in wound management, routine integration of such a concept into daily clinical practice remains challenging and requires significant cultural, structural and organisational changes within individual national healthcare systems.

A comprehensive medical history that focuses on the individual and their personal circumstances is crucial for determining the type and scope of subsequent therapeutic interventions. Person-centred care represents a valuable approach to improve healing outcomes in professional wound management.



Octenidine-dihydrochloride

02 Different types of wounds: Main definitions and clinical classifications

Wounds are defined as breakdown of the protective function of the skin; loss of continuity of epithelium, with or without loss of underlying connective tissue, such as muscle, bone and nerves.⁴

Based on aetiology, depth, extent and time to complete closure, a wide range of wound types can be distinguished, which may differ substantially in their management approaches. Mainly depending on the nature of the healing process, wounds are commonly classified into two main categories: acute wounds and chronic wounds.

Acute wounds commonly result from external injury, such as mechanical trauma, exposure to heat or cold, chemical agents or ionising radiation, and typically progress through the phases of healing in a normal and timely manner. However, as the skin's natural protective barrier is disrupted, acute wounds are particularly susceptible to infection.⁵

Types and characteristics of acute wounds

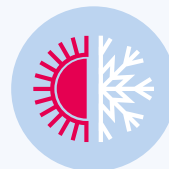


Traumatic wound

A traumatic wound is an injury caused by external mechanical forces, such as sharp or blunt trauma, pressure, tension or shear. Traumatic wounds include accidental injuries (e.g. abrasions, incisions, puncture wounds, lacerations, bite wounds, crush injuries, gunshot wounds) as well as surgically created wounds and amputations.

Thermal wound

A thermal wound is tissue damage resulting from exposure to extreme temperatures, either heat or cold (e.g. burn, scald, contact, flame, electrical injury, frostbite). Thermal wounds can vary in depth and severity depending on the temperature, duration of exposure and affected tissue.



Chemical wound

A chemical wound is an injury caused by exposure to corrosive or irritant chemical substances (e.g. acids, alkalis, oxidisers, solvents). Tissue damage results from chemical reactions that disrupt cellular structures and may continue until the chemical agent is neutralised or removed. Severity depends on type, concentration, quantity as well as kind (solid/power versus liquid/gas) and duration of exposure.

Radiation-induced wound

A radiation-induced wound is an injury to the skin and subcutaneous tissue resulting from exposure to ionising radiation (accidental, occupational or therapeutic), typically characterised by delayed onset and a prolonged, often fluctuating healing course. Sunburn caused by ultraviolet radiation is also classified within this category.



The management of acute wounds requires timely and evidence-driven interventions to achieve optimal functional and aesthetic outcomes.

Chronic wounds fail to progress through the normal stages of healing in an orderly and timely manner and do not heal within an expected timeframe. They frequently stall in the inflammatory phase, characterised by persistent inflammation, impaired cell signalling, reduced angiogenesis and degradation of the extracellular matrix. In most cases, chronic wounds are associated with underlying medical conditions such as venous, arterial, or metabolic vascular disease, pressure-related tissue damage, cardiovascular disorders or malignancy. They may also arise from an unrecognised persistent microbial colonisation/infection or inadequate initial management of an acute wound.

Defining chronic wounds remains challenging. Time-based criteria alone are insufficient, as chronic wounds are highly heterogeneous with respect to aetiology, pathogenesis, size, anatomical location, comorbidities and patient-related factors. Based on current scientific publications and recommendations from various wound healing societies, chronic wounds may be further categorised as hard-to-heal, non-healing and non-healable wounds. Consequently, complete wound closure is not always the primary objective of an individualised treatment strategy. In many cases, other aspects, such as optimising quality of life, promoting health-related self-management and preventing further complication, may take precedence.

Multiple definitions of chronic wounds

"A wound that has not healed after eight weeks is considered a chronic wound. Independent of this time-based definition, some wounds are regarded as chronic from the outset, as their management requires treatment of an ongoing underlying cause. These include, for example, diabetic foot ulcers, wounds associated with peripheral arterial occlusive disease, venous leg ulcers and pressure ulcers."

Dissemond et al., Diagnostik und Therapie chronischer Wunden. Initiative Chronische Wunden (ICW) e.V. 2023 (translated from German)

"Chronic wound: A wound that makes slow progression through the healing phases or displays delayed, interrupted or stalled healing. Inhibited healing may be due to intrinsic and extrinsic factors that impact on the person, their wound and their healing environment."

International Wound Infection Institute (IWII), Wound Infection in Clinical Practice. Wounds International 2022

"Hard-to-heal wound: Wound that has failed to progress through the phases of healing in an orderly and timely fashion and has shown no significant progress toward healing in 30 days (also known as chronic wound or non-healing wound)."

Mayer et al., International Consensus Document, Best Practice for Wound Debridement. Journal of Wound Care 2024

"A chronic wound is defined as a loss of skin integrity, with or without involvement of one or more underlying structures, that fails to heal within eight weeks."

"Hard-to-heal wounds are wounds that are a manifestation of an underlying disease and/or whose healing is delayed due to intrinsic or extrinsic patient-related factors and/or that impair quality of life."

Deutsche Gesellschaft für Wundheilung und Wundbehandlung e.V., Lokalthherapie schwerheilender und/oder chronischer Wunden aufgrund von peripherer arterieller Verschlusskrankheit, Diabetes mellitus oder chronischer venöser Insuffizienz. Version 2.2 Stand: 31.10.2023 | AWMF-Register-Nr.: 091/001 (translated from German)

"A hard-to-heal wound is a wound that has failed to respond as expected to evidence-based standard of care. A hard-to-heal wound can be a wound of any origin, type and aetiology, including both simple and complex wounds."

Murphy et al., International Consensus Document – Wound Hygiene Surgical. Journal of Wound Care 2024

"Non-healing wounds: Wounds that fail to progress through an orderly and timely sequence of repair. Also referred to as chronic, complex and hard to heal wounds."

Probst et al., Antimicrobials and Non-healing Wounds: An Update. Journal of Wound Management 2022

"Common features shared by chronic wounds include prolonged or excessive inflammation, persistent infections, formation of drug-resistant microbial biofilms, and the inability of dermal and/or epidermal cells to respond to reparative stimuli."

Frykberg and Banks, Advances in Wound Care 2015

"A chronic wound is one that fails to progress through a normal, orderly, and timely sequence of repair, or in which the repair process fails to restore anatomic and functional integrity."

Bowers and Franco, American Family Physician 2020

Chronic wound care is defined by complexity and requires a continuous reassessment of the healing progress and person-centred therapeutic goals.

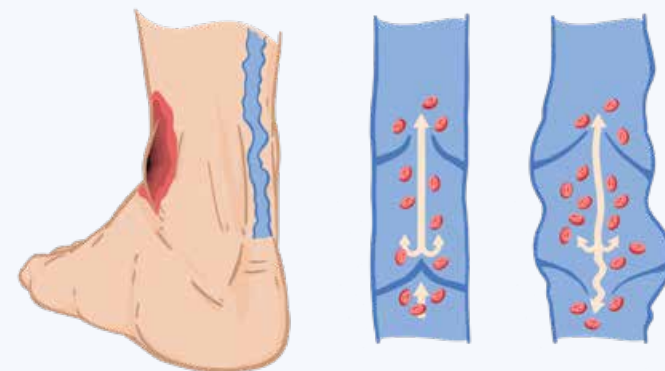
Most common types of chronic wounds

Chronic wounds represent a major public health challenge due to prolonged healing times and their frequent association with comorbidities such as diabetes mellitus and vascular disease. They substantially impair people's quality of life and impose an increasing economic and logistical burden on healthcare systems as a result of long-term treatment requirements. In developed countries, chronic wounds affect approximately 1–2% of the general population, with prevalence rising markedly among the steadily growing geriatric population.

Venous leg ulcer (VLU)

VLUs, caused by chronic venous insufficiency, are the most frequent clinical presentation of chronic wounds, with a prevalence of approximately 1–5%. Venous dysfunction impairs effective blood return to the heart, leading to venous hypertension and congestion. This results in compromised tissue perfusion, altered metabolism and reduced oxygenation, ultimately causing tissue damage and ulceration. VLUs are typically located in the lower-leg region around the medial malleolus and are associated with oedema, lipodermatosclerosis, haemosiderosis and stasis dermatitis. Established risk factors include a history of deep vein thrombosis, chronic venous hypertension, trauma, multiple pregnancies and advanced age.

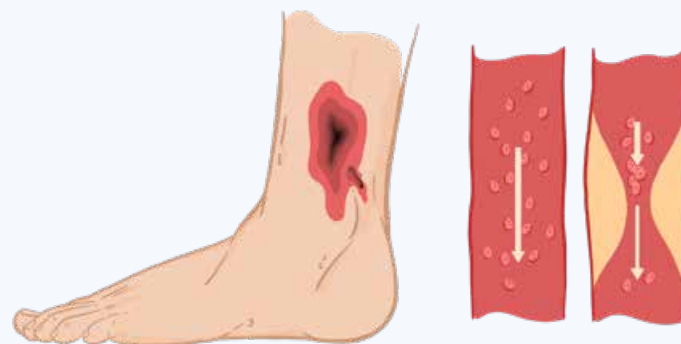
Venous leg ulcer: Intact venous valve with normal blood flow versus chronic venous insufficiency.



Arterial leg ulcer

Arterial disease accounts for up to 25% of leg ulcers. As a consequence of atherosclerosis, calcium deposits accumulate in the arteries of the lower leg, leading to impaired perfusion, reduced oxygenation and ultimately tissue breakdown. In advanced stages of peripheral arterial occlusive disease, extensive tissue damage may compromise the viability of the entire limb. Arterial ulcers typically occur at sites exposed to pressure or minor trauma, such as over bony prominences and at distal locations including the toes. Key risk factors include diabetes mellitus, smoking, hyperlipidaemia, hypertension, obesity and advanced age.

Arterial leg ulcer: Intact artery with normal blood flow versus atherosclerosis.



Arteriovenous leg ulcer

Approximately 20% of patients with chronic wounds have mixed wounds with concomitant peripheral arterial disease and venous insufficiency, which is associated with slower healing and increased rates of recurrence.

Diabetic foot ulcer (DFU)

DFUs result from a spectrum of sensory and musculoskeletal changes affecting the foot that are attributable to the underlying disease diabetes mellitus. Beyond ulceration, the dorsum of the foot, malleoli or distal toes are frequently deformed or damaged. Impairments in sensory, motor and autonomic nerve function, as well as compromised vascular function, further increase the risk of ulceration. Repetitive pressure from inappropriate footwear and insufficient or improper foot care are additional key contributing factors.

DFUs are the leading cause of hospitalisation and amputation among people with diabetes mellitus, with signs of infection present in approximately 50–60% of patients at the time of admission.

Thus, effective management of DFUs requires both control of the underlying metabolic disorder and meticulous local wound care to prevent deterioration, reduce the risk of major complications, and promote optimal healing.

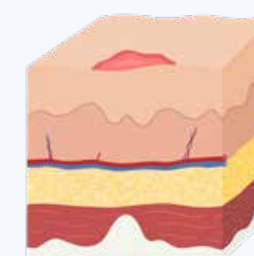


Diabetic foot ulcer.

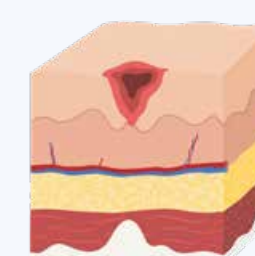
Pressure injury

Pressure injuries, also referred to as pressure ulcers, are localised injuries to the skin and/or underlying tissue, usually over bony prominences (e.g. sacrum, heels) resulting from sustained pressure or pressure in combination with shear forces. They most commonly occur in people with limited mobility and are associated with impaired tissue perfusion and oxygenation. Risk factors include immobility, advanced age, sensory impairment, malnutrition, and comorbidities such as diabetes mellitus. Pressure injuries represent a significant clinical challenge and require early risk assessment, preventive measures, and appropriate local wound management.

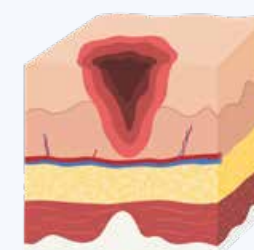
The *European Pressure Ulcer Advisory Panel*, the *National Pressure Injury Advisory Panel* and the *Pan Pacific Pressure Injury Alliance* have developed a joint international definition and classification system for pressure injuries.⁶



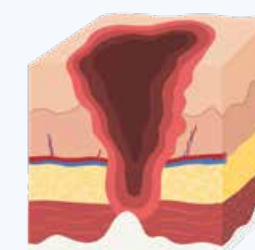
Category/stage I:
Non-blanchable erythema



Category/stage II:
Partial-thickness skin loss



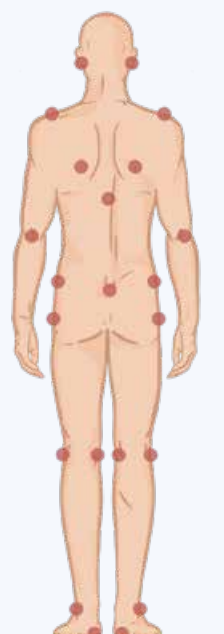
Category/stage III:
Full-thickness skin loss



Category/stage IV:
Full-thickness tissue loss

Special cases include:

- Unstageable: Depth unknown
- Suspected deep tissue injury: Depth unknown



Pressure injury:
Areas at risk are typically
located over bony prominences.

03 The science of wound healing: Key definitions and processes

Wound healing is a coordinated sequence of cellular and molecular events that repairs tissue damage and restores the integrity of the skin and underlying structures.

The physiological process of wound healing normally proceeds in an orderly and spontaneous manner. However, appropriate wound assessment and evidence-based management may optimise healing outcomes. In clinical practice, wound healing is typically classified into three categories: **healing by primary, secondary or tertiary intention**.

Epithelial wound healing represents a distinct form that is limited to superficial injuries such as sunburn or minor abrasions and is typically completed within a few days. In this process, the epidermis regenerates without the formation of granulation tissue or wound contraction, generally resulting in no scarring.

Classification of wound healing

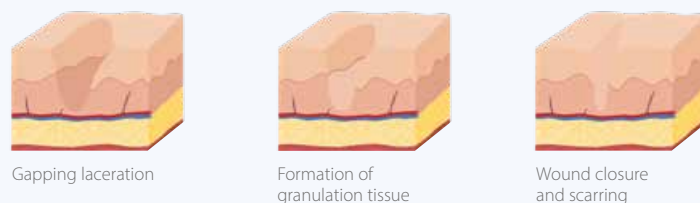
Primary intention wound healing

Primary intention wound healing occurs when wound edges are smooth and closely approximated, tissue loss is minimal, perfusion is adequate and infection or foreign material is absent. Under these optimal conditions, wound closure proceeds rapidly, typically within several days to one week, and results in minimal scar formation. Primary healing is characteristic of surgically closed wounds, sharp traumatic injuries such as incisions and large superficial defects.



Secondary intention wound healing

In secondary intention wound healing, tension-free primary closure is not possible due to extensive tissue loss, widely separated wound margins and/or infection. Wound closure relies on granulation tissue formation, wound contraction and re-epithelialisation to bridge the defect, and is typically associated with a more pronounced inflammatory response and increased scarring. Healing may take several months and is characteristic of acute wounds with substantial tissue loss (e.g. bite injuries), severe burns or chronic wounds.

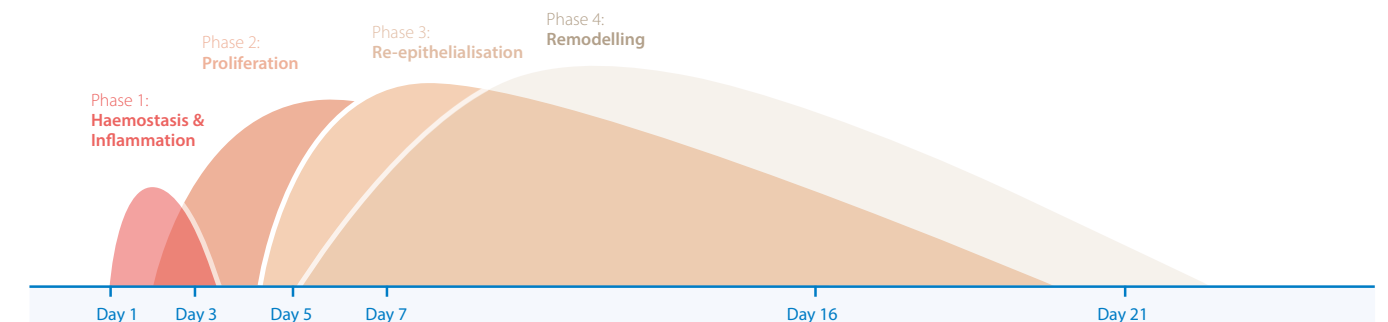


Tertiary intention wound healing

Tertiary intention healing (also referred to as delayed primary closure) occurs when a wound is initially left open to allow for cleansing, drainage and infection control in high-risk or contaminated defects. Once conditions permit, the wound is closed similarly to primary intention, potentially using grafts, flaps, or skin substitutes, predominantly involving a prolonged healing course.

Pathophysiology of wound healing

The wound healing process is a physiological reaction immediately initiated following tissue injury. It is a dynamic and multi-stage biological response comprising four overlapping phases, each regulated by complex interactions between numerous cell types, immunoregulatory mediators and the vascular system.



Phase 1: Haemostasis & Inflammation

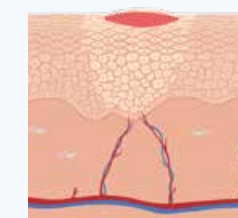


Haemostasis starts within the first minutes of injury to rapidly control bleeding through platelet activation and coagulation, resulting in a fibrin-rich clot that seals the defect. Neutrophils, macrophages and other inflammatory cells are further recruited to the wound site to phagocytose cell debris, foreign particles and pathogens, and to release pro-inflammatory cytokines, growth factors and proteases. This phase typically lasts from 1 to 4 days after injury and prepares the wound for regeneration by signalling the recruitment and activation of fibroblasts and epithelial cells.



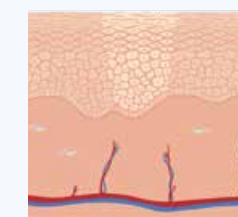
Phase 2: Proliferation

Approximately four days after injury, granulation tissue forms to fill the wound defect and restore tissue continuity. Fibroblasts proliferate and synthesise key components of the extracellular matrix (e.g. procollagen, hyaluronic acid, elastin), creating a structural scaffold for tissue repair. Concurrently, angiogenesis develops to supply oxygen and nutrients to the metabolically active wound bed. Clinically, the wound typically appears well perfused, moist and bright red to translucent. Formation of granulation tissue provides the essential foundation for subsequent re-epithelialisation.



Phase 3: Re-epithelialisation

From approximately day 6 to 10, re-epithelialisation begins as epithelial cells migrate from the wound edges across the surface of the granulation tissue to cover the defect. The wound gradually contracts, collagen fibres mature and granulation tissue becomes progressively less vascularised and hydrated, transforming into scar tissue. Increasing epithelial coverage enables wound closure and is clinically characterised by a fine, pale pink surface, accompanied by a reduction in wound exudation.



Phase 4: Remodelling

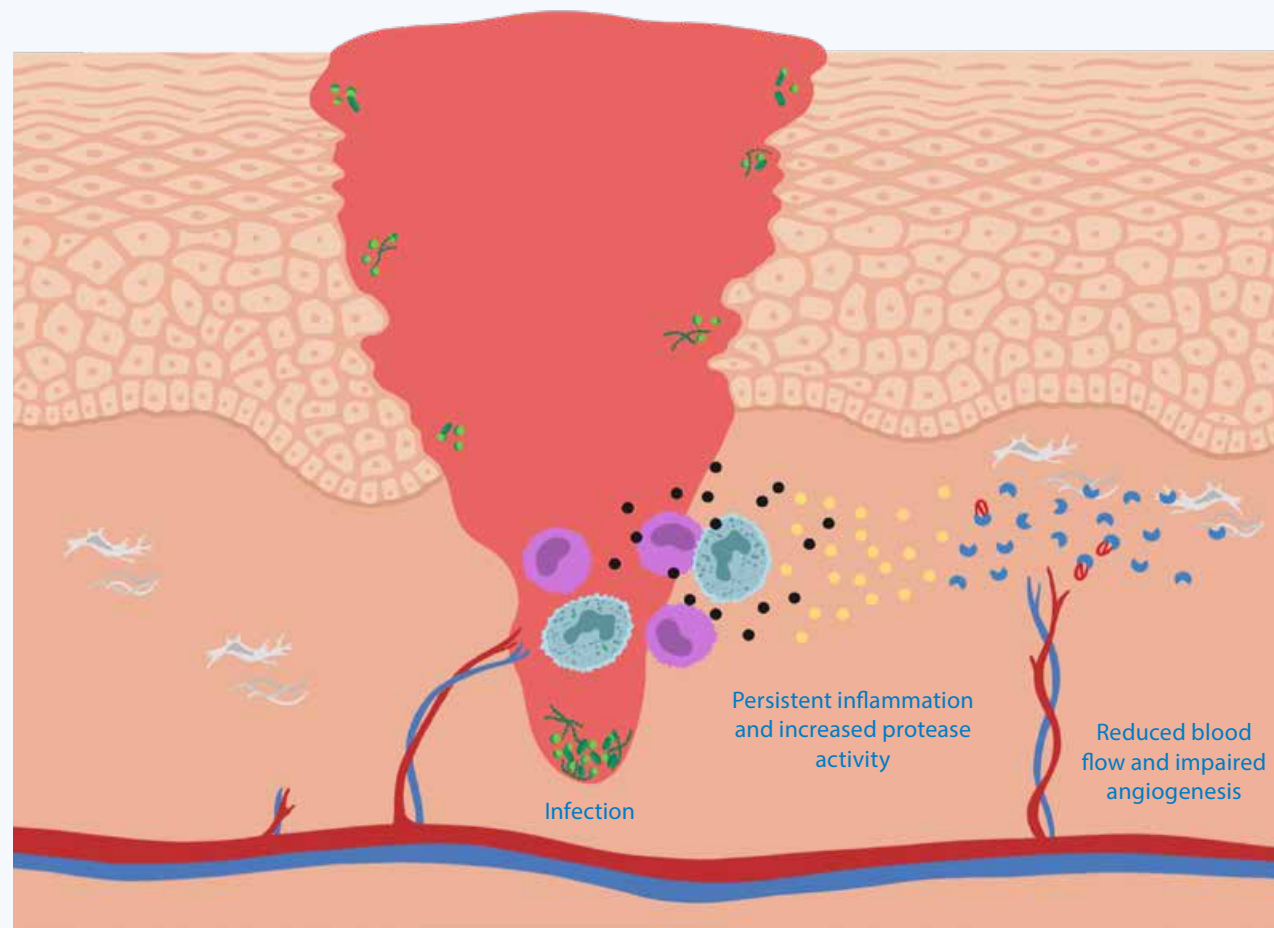
The final stage of the healing process involves tissue maturation and remodelling, which may last up to 12 months. During this phase, collagen is reorganised and dermal tensile strength increases to approximately 80% of normal skin. However, healing results in scar tissue rather than full skin regeneration, characterised by thin, poorly vascularised tissue lacking essential epidermal structures, such as sebaceous and sweat glands, pigment cells and neural innervation.

Factors influencing wound healing

Wound healing involves far more than the simple closure of a tissue defect. It is a complex process at the cellular and molecular level that requires precise coordination of multiple biological mechanisms.

Not all wounds heal rapidly or predictably. A wound healing disorder is a deviation from the physiological wound healing process in which progression through the normal phases of healing is delayed, impaired, or arrested due to a

range of individual local and/or systemic factors, resulting in prolonged healing or the development of a chronic wound. Both, speed and quality of wound healing are influenced not only by wound-specific characteristics such as location, depth and size, but also by the individual's overall condition, including age, nutritional and immune status, chronic underlying diseases (e.g. diabetes mellitus, vascular disorders, anaemia, malignancy), postoperative complication, acute trauma and medication.



Factors impairing re-epithelialisation and delaying wound closure.

- | | | |
|---|---|---|
|  Fibroblasts |  Pathogens (e.g. bacteria, fungi) |  Matrix metalloproteinases (MMPs) |
|  Neutrophils |  Inflammatory mediators (e.g. cytokines, chemokines) |  Tissue inhibitors of metalloproteinases (TIMPs) |
|  Macrophages |  Growth factors |  Extracellular matrix (ECM) |

Wound infection is regarded as one of the most common and clinically significant disturbances of the wound healing process. It is caused by a broad spectrum of microorganisms – predominantly bacteria and fungi, and less frequently viruses – that invade the wound, proliferate and produce cytotoxic substances. This leads to tissue destruction and may result in necrosis. Activation of local host defence mechanisms prolongs the inflammatory phase and thereby delays progression of healing. With increasing wound duration, the risk of systemic spread rises and, in severe cases, infection may progress to life-threatening sepsis.

Numerous scientific studies published in recent years have demonstrated that a variety of cell types and regulatory signalling molecules, including growth factors, cytokines, chemokines and components of the extracellular matrix (ECM), are involved in the multistage wound healing process. Moreover, fundamental differences in the local microenvironment between acute and chronic wounds have been identified, along with promising molecular biomarkers for monitoring healing progression.

In that context, **matrix metalloproteinases (MMPs)** play a key role as proteolytic enzymes in every phase of wound healing. They regulate processes such as the removal of damaged ECM fragments, support microbial wound cleansing, and coordinate complex cell-cell interactions required for granulation tissue formation, as well as cell-matrix interactions that initiate re-epithelialisation and ultimately lead to wound closure. Under physiological healing conditions, MMP levels rise rapidly during the first days after injury and decrease to very low levels within approximately one week. MMP activity is primarily regulated by tissue inhibitors of metalloproteinases (TIMPs), ensuring balanced tissue remodelling.

Restoring physiological wound healing requires breaking the cycle of excessive inflammation and protease activity through targeted modulation of the wound microenvironment.

In many chronic wounds or acute wounds with delayed healing, a pronounced imbalance between MMPs and TIMPs has been observed. MMP levels are not only elevated but remain persistently increased over prolonged periods, creating an unfavourable wound healing microenvironment. Excessive MMP activity leads to degradation of the ECM, damage to newly formed tissue and impairment of the wound bed, ultimately disrupting the healing process.

Ongoing tissue damage drives sustained infiltration of inflammatory cells, such as **neutrophils** and **macrophages**, into the wound. These cells continuously release **pro-inflammatory cytokines**, which further stimulate MMP production while simultaneously reducing TIMP synthesis. In addition, **growth factors** and their receptors on target cells are degraded, preventing adequate stimulation of tissue repair and perpetuating the inflammatory response.

When the physiological sequence of wound healing is temporally disrupted and the body is no longer able to restore tissue integrity autonomously, a **chronic wound** may develop, often characterised by a prolonged inflammatory phase. In this context, in addition to patient-specific and local causal factors (e.g. underlying diseases, pressure-related tissue damage, infection), elevated levels of specific cytokines, chemokines and proteases have been identified as key contributors to impaired healing.

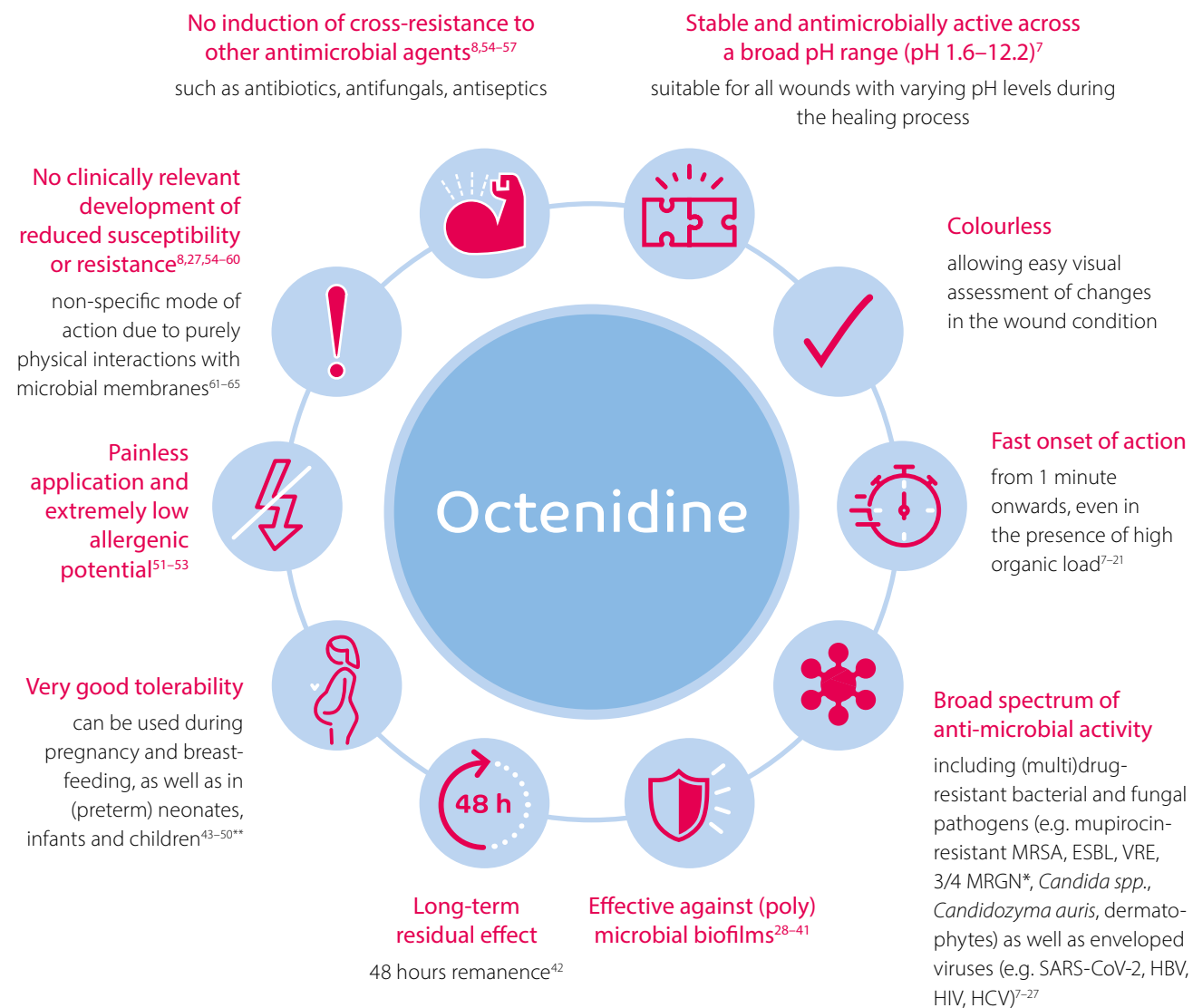
Furthermore, **hypertrophic scars** and **keloids** are often associated with dysregulated activity of signalling molecules. Evidence from recent literature indicates that a shorter inflammatory phase is linked to improved scar quality.

04 Octenidine: Trusted performance driven by innovation

Octenidine has been successfully used as an antimicrobial agent for more than 35 years and is well established across a wide range of clinical applications.

Given the increasing global prevalence of persistent (multi) drug-resistant pathogens and limited therapeutic options, octenidine continues to play an important role in clinical practice. Owing to its broad spectrum of anti-microbial

activity and favourable safety profile, octenidine remains a trusted antiseptic agent more than 35 years after its initial clinical introduction.



* Multidrug-resistant (MR) Gram-negative (GN) pathogens; 3MRGN – resistance to three out of the following antibiotic substances: penicillins, cephalosporins, quinolones and carbapenems; 4MRGN – resistance to all four pre-cited classes.
** Please consider respective SmPC/product information for further information.

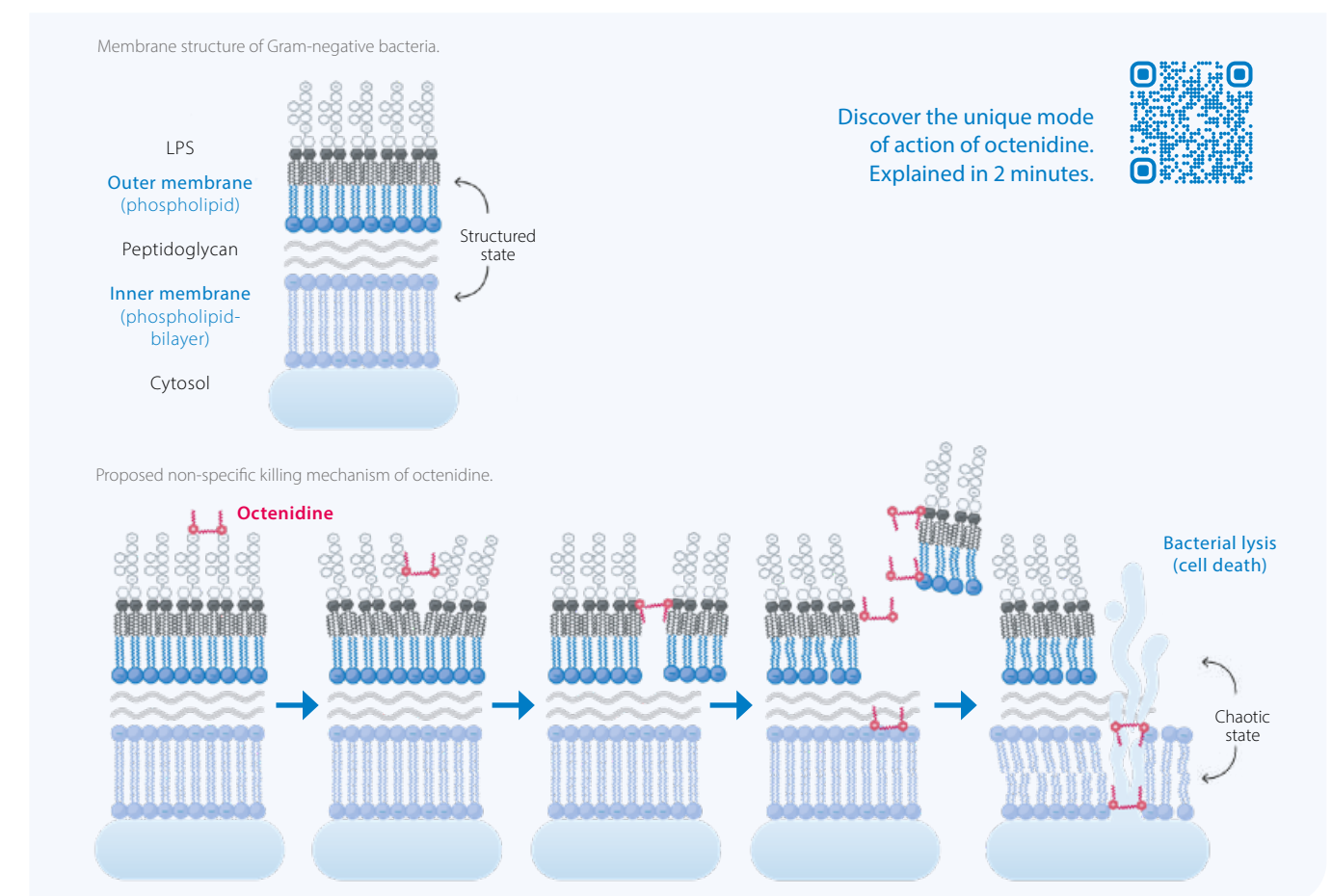
Non-specific mode of action

Despite its long history of successful clinical use, fundamental insights into the detailed cellular and molecular mechanism of action of octenidine against clinically relevant Gram-negative and Gram-positive bacteria as well as fungi have only recently been elucidated using advanced biophysical investigations.⁶¹⁻⁶⁵

Driven by electrostatic interactions, octenidine rapidly associates with the outer membrane of Gram-negative bacteria and penetrates through the lipopolysaccharide (LPS) layer. Subsequent hydrophobic interactions enable the hydrocarbon chains of octenidine to insert between bacterial membrane lipids, inducing pronounced membrane disorder based on hydrophobic mismatch and thereby disrupting membrane integrity. As a result, additional octenidine molecules can penetrate from the outside

through the periplasmic space to the inner membrane, affecting its integrity in an analogue manner. This cascade of membrane damage ultimately leads to rapid bacterial lysis.

To date, no clinically relevant reduction in susceptibility to octenidine nor the development of (cross)resistance to other antimicrobials has been reported.^{8,27,54-60} This is consistent with its non-specific mode of action, which is mediated by purely physical interactions with lipid membranes of bacteria and fungi rather than by targeting specific metabolic or enzymatic pathways. By interfering with essential and evolutionarily conserved membrane structures, octenidine exhibits a mode of action that makes the emergence of resistance to octenidine highly unlikely, both currently and in the future.



Octenidine acts rapidly and effectively. Due to its non-specific mode of action, the development of resistance is considered unlikely.

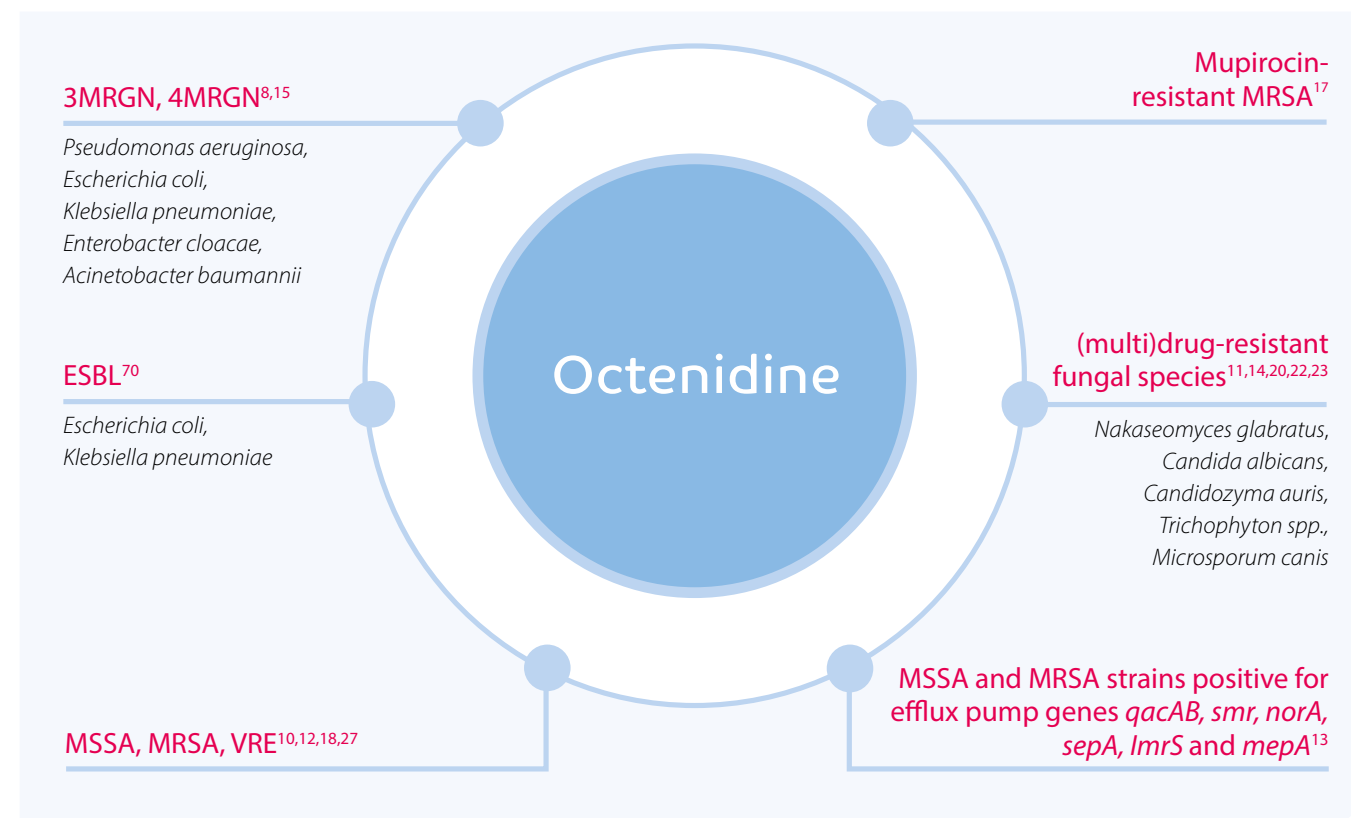
Rapid and effective against clinically relevant emerging pathogens

In light of the increasing global prevalence of (multi)drug-resistant pathogens and the associated limitations of available therapeutic options, antiseptics with alternative mechanisms of action, such as octenidine, play an important role in local wound management.^{66,67}

In principle, every wound carries an inherent risk of infection. While *Staphylococcus aureus* is regarded as one of the most important causative agents of postoperative wound infections, a more diverse spectrum of pathogens is observed in acute and chronic wounds (e.g. *Pseudomonas spp.*, *Enterococcus spp.*, *Streptococcus spp.*, *Acinetobacter baumannii*). However, in addition to bacteria, clinically serious wound infections may also be caused by pathogenic fungi. An increasing body of scientific evidence has documented the presence of various yeasts, moulds and dermatophytes

in hard-to-heal wounds. However, due to the traditional focus on bacterial pathogens and the more complex laboratory diagnostics required, fungal infections often remain undetected. Consequently, their role as causative agents of clinically relevant infections is frequently underestimated, posing emerging challenges for diagnostic and therapeutic strategies.^{68,69}

The broad and comparatively rapid antimicrobial activity of octenidine against Gram-positive and Gram-negative bacteria as well as fungi, including (multi)drug-resistant clinical isolates, has been extensively demonstrated in numerous *in vitro* studies. Importantly, the efficacy of octenidine is maintained even under conditions of high organic load, such as the presence of blood, proteins, mucin or human wound exudate.⁷⁻²¹



Continuous monitoring of wound healing is essential, as both acute and chronic wounds carry an inherent risk of bacterial and fungal infection that can delay the healing process, reduce people's quality of life and increase the demands of ongoing care.

Effective against (poly)microbial biofilms

Different bacteria and/or fungi can form within hours a (poly)microbial biofilm by embedding themselves in a protective matrix of extracellular polymeric substances. Within this shared matrix, microorganisms exhibit increased tolerance to therapeutic agents, exchange (resistance) genes and engage in mutually beneficial interactions. Persistent biofilms pose a major challenge to the host immune response, leading to stagnation of physiological wound healing, potentially further contributing to the development of a chronic wound.⁷¹

In clinical practice, the detection of biofilms is often challenging, and microorganisms residing within biofilms may evade antimicrobial activity. Effective wound management therefore requires an early, structured approach and a thorough understanding of therapeutic interventions to reliably disrupt biofilms. In this context, the concept of "Wound Hygiene", as first described by Murphy et al. 2020, provides a

proactive, structured strategy applicable to all wounds, aimed to reduce the microbial burden and to prevent infection and chronicity. It emphasises regular wound cleansing, debridement, refashioning the wound edges and the targeted use of antimicrobial agents to disrupt any residual biofilms and/or to prevent their reformation, regardless of any visible signs of infection. By consistently controlling the wound microenvironment, these four key measures support healing progression and reduce the risk of delayed or stalled healing.⁷²⁻⁷⁴

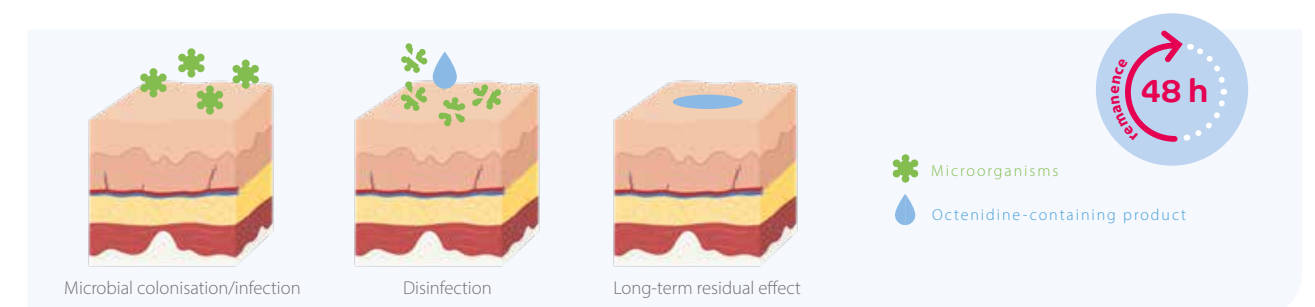
Thus, initial wound management comprises thorough wound cleansing and/or effective debridement to remove debris, necrotic tissue, and biofilm, followed by the application of a broad-spectrum antimicrobial agent prior to the dressing. In addition to appropriate local wound care, underlying conditions contributing to impaired wound healing should be identified through holistic assessment and addressed with causal treatment.⁷⁵

Octenidine permeates (poly)microbial biofilms and effectively eliminates embedded microorganisms.²⁸⁻⁴¹

Long-term residual effect

Residual activity refers to the persistent effect of an active substance after application, during which it continues to exert antimicrobial activity and inhibits microbial growth, thereby effectively preventing infection. In wound care, a long-term residual effect is of particular importance. It not only eliminates pathogens already present in the wound

but also targets newly invading microorganisms, including those originating from the individual's own skin flora. Octenidine is not systemically absorbed but remains on the body surface,^{76,77} where its broad antimicrobial activity has been demonstrated to last for at least 48 hours.⁴²



To maintain their residual antimicrobial activity, octenidine-containing products should not be rinsed off after application.

High biocompatibility index

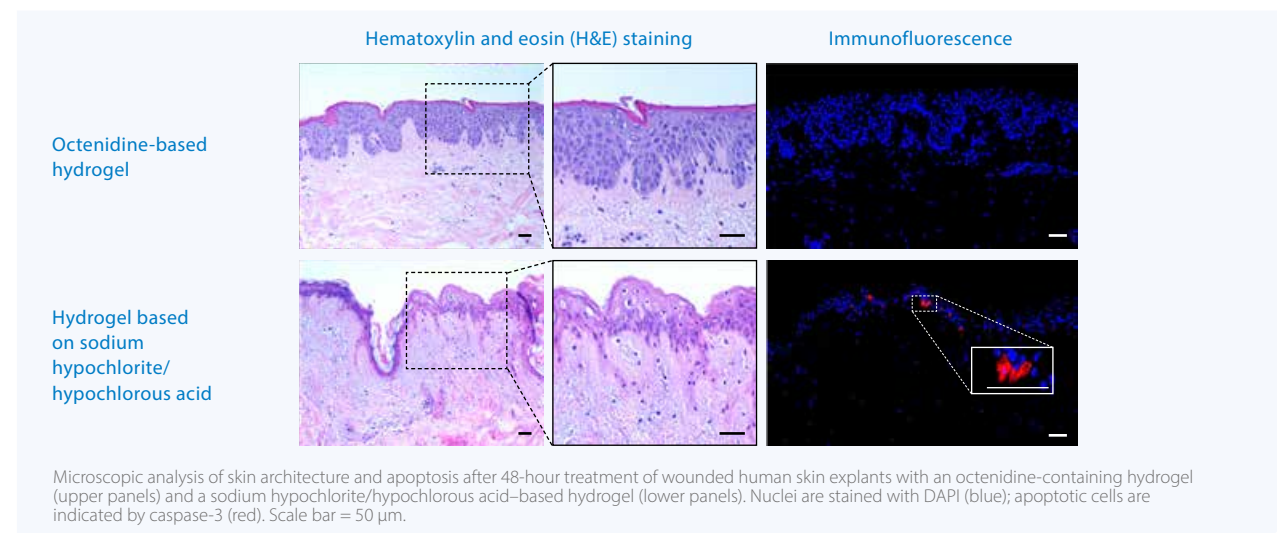
Because topical antimicrobial agents may remain in contact with the wound for prolonged periods, tissue compatibility is of critical importance. To enable a standardised comparison of different antiseptics, Müller and Kramer introduced the “Biocompatibility Index” (BI) in 2008, defined as the ratio between antimicrobial efficacy and cellular cytotoxicity under identical *in vitro* test conditions.⁷⁸ A high BI indicates an antiseptic with strong antimicrobial activity and low cytotoxicity, whereas a BI < 1 reflects predominant

cytotoxic effects and has been proposed as a threshold below which antiseptics should no longer be used. In direct comparison with other widely used antiseptics in wound management, such as polyhexanide or PVP-iodine, octenidine demonstrated one of the highest reported BI values. This favourable balance between broad antimicrobial efficacy and good tissue compatibility supports its safe use in long-term wound care.

No cytotoxic effects on human skin cells

Moist wound management using hydrogels is widely accepted as state-of-the-art for promoting re-epithelialisation and supporting physiological wound healing.⁷⁹ In this context, the tissue compatibility of an octenidine-based hydrogel was recently evaluated in comparison with other hydrogels containing antiseptic agents, such as polyhexanide or PVP-iodine, as well as formulations based on sodium hypochlorite/hypochlorous acid, using a standardised *ex vivo* human skin model. In this comparative assessment, punch biopsies of human skin were obtained and superficially wounded using a tape-stripping method. Subsequently, different commercially available wound gels were

applied topically, and respective skin biopsies were cultured for 48 hours. Histological and immunofluorescence analyses demonstrated that the octenidine-based hydrogel preserved epidermal and dermal architecture and showed no evidence of cytotoxic effects on human skin cells. By contrast, several wound gels containing sodium hypochlorite/hypochlorous acid caused marked structural alterations and a significant increase in apoptotic skin cells. These findings highlight substantial differences in tissue compatibility and mode of action among commonly used wound gels and highlight the favourable tolerability profile of octenidine-based hydrogels in wound care.^{80,81}



Despite its rapid and potent antimicrobial activity, octenidine has been shown to be non-cytotoxic to human tissue in clinical use and is therefore recommended as an agent of choice even in highly vulnerable patient populations such as neonates.^{47,48}

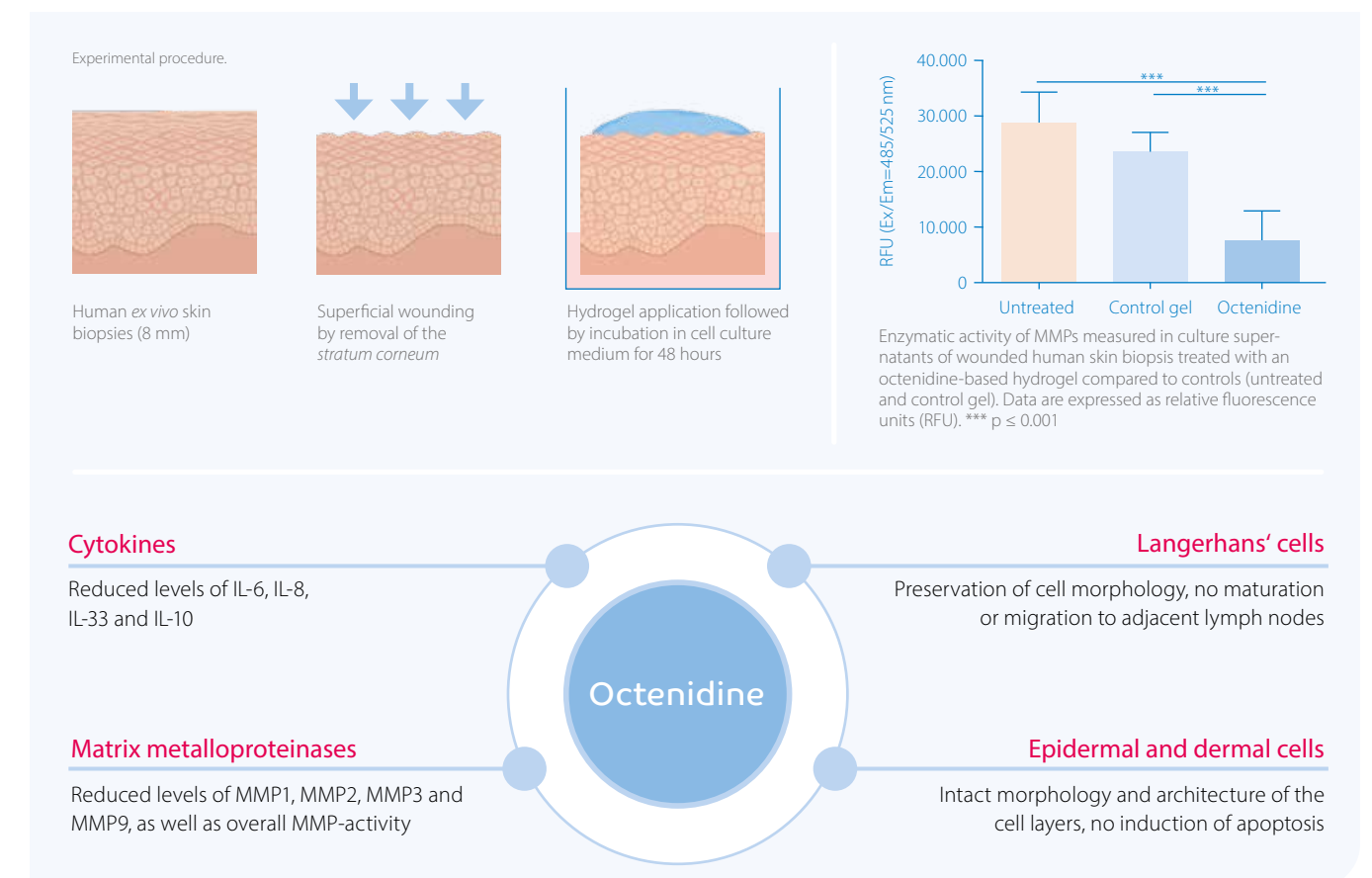
Anti-inflammatory and protease-inhibiting properties

Recent investigations on a molecular level indicate that wound healing outcomes are closely linked to the interplay of various cell types, inflammatory mediators, growth factors and the activity of proteolytic enzymes. In this context, a shorter inflammatory phase appears to have a positive impact on both healing time and subsequent scar quality.^{82,83}

This effect was investigated in more detail for octenidine using a superficial human *ex vivo* skin wound model. During the healing process, the octenidine-containing hydrogel demonstrated significant anti-inflammatory and protease-inhibitory properties, characterised by the suppression of interleukins (IL)-6, IL-8, IL-10 and IL-33, as well as matrix metalloproteinases (MMP)1, MMP2, MMP3 and MMP9. In parallel,

activation and migration of Langerhans' cells to adjacent lymph nodes were reduced. Importantly, these effects were specific to octenidine, as direct comparison with an otherwise identical hydrogel lacking octenidine showed that the immunomodulatory and protease-inhibitory benefits were not attributable to moist wound treatment alone.^{80,84}

Furthermore, complementary studies using the same *ex vivo* wound model revealed that different antiseptic molecules or chlorine-based and chlorine-releasing agents in hydrogels exerted significantly distinct effects on wounded human skin. The octenidine-containing wound gel demonstrated the most pronounced anti-inflammatory and protease-inhibitory capacities compared to other hydrogel formulations.⁸¹



The application of an octenidine-containing hydrogel maintains low levels of inflammation and proteolytic activity in the wound and triggers immunomodulatory responses that may support progression from the inflammatory to the proliferative phase of healing.

Improved scar quality

Evidence from preclinical studies and clinical observations suggests that octenidine provides both strong anti-microbial activity and positive support for the wound healing process.^{85–95} In that context, hypertrophic scars and keloids represent not only a cosmetic concern for affected individuals but may also be associated with functional impairment and pain. Consequently, preventing excessive scar formation is an important therapeutic objective, and appropriate treatment decisions should be considered early during wound management.

In a clinical study employing an intra-individual design, patients undergoing abdominoplasty experienced clear benefits from the immediate postoperative use of an octenidine-containing wound gel. In addition to a noticeable reduction in perceived pain during dressing changes, treatment with the octenidine-based hydrogel was associated with fewer wound healing disorders, a lower incidence of hypertrophic scars and keloids, reduced transepidermal water loss and improved skin elasticity compared with conventional wound care.⁹⁶



Scar quality of a 47-year-old female patient twelve months after abdominoplasty. Postoperative wound care was performed immediately after surgery using an octenidine-based wound gel in combination with a transparent film dressing (left image) or Omnistrip® strips, showing marked hypertrophic scar formation (right image).

Immediate postoperative wound care with an octenidine-based hydrogel establishes a moist wound environment, helps to protect the wound from infection, supports the physiological healing process and contributes to improved functional and aesthetic scar outcomes.

Promotion of wound healing and cost efficiency

The clinical value of octenidine-based products in the management of chronic wounds has been confirmed in recent years by several studies and numerous case reports.^{89–95} This is particularly relevant for venous leg ulcers, which represent one of the most common chronic wounds of the lower extremities and are associated with prolonged treatment duration and substantial healthcare costs.

In a randomized, double-blind controlled clinical study, octenidine demonstrated very good tissue tolerability in the treatment of chronic venous leg ulcers over a period of three months, alongside improvements in patient's quality of life. Notably, octenidine-based therapy resulted in significantly improved healing outcomes compared with the

control group receiving Ringer's solution, particularly in patients with ulcers of more than six months' duration and larger wound areas.⁸⁹

In a further prospective case-controlled trial, an octenidine-based hydrogel outperformed other modern wound dressings, including foam and alginate dressings with or without silver. Throughout the six-week study period, octenidine-treated venous leg ulcers exhibited faster granulation tissue formation and a significantly greater reduction in wound area. Moreover, local treatment with the octenidine-containing hydrogel was identified as the most cost-efficient therapeutic approach.⁹⁰

05 Octenidine-based product portfolio: Antisepsis for improved wound healing

Every wound poses an inherent risk of infection. Accordingly, both proper initial care and subsequent treatment play a key role in supporting optimal healing.

Wound infections are quite common in clinical practice and considered to be one of the most serious challenges hindering the wound healing process. In light of the global rising of antimicrobial resistance and the emergence of (multi) drug-resistant bacteria and fungi, the use of antiseptics for the prevention and management of wound infection is

increasingly explored. Early, judicious application of topical antiseptics can limit biofilm formation, prevent microbial regrowth, and reduce the further spread of an already present infection. At the same time, responsible antibiotic and antifungal stewardship remains essential to preserving their therapeutic efficacy for future generations.



* Indications and labels are according to the Austrian registration of the corresponding products and may differ in other countries. Please consider respective SmPC/product information for further information.

Octenidine-based products provide a unique advantage by utilizing a single, well-characterised active ingredient, ensuring optimal compatibility while preventing any unwanted product interactions.

Comprehensive wound care solutions

schülke's integrated, octenidine-based product range enables simple, indication-based treatment across all wound situations, supporting the natural healing process in an individualised and phase-appropriate manner.

octenisept®* aqueous wound and mucous membrane antiseptic



Key benefits

- Broad spectrum of antiseptic activity
- Fast onset of action
- Very good tolerability
- Suitable for (preterm) neonates and children
- Safe use during pregnancy and breastfeeding
- Colourless and painless
- Supports effective wound cleansing

Shelf life after opening: 3 years (do not use beyond the stated expiry date).

Ready-to-use medicinal product. Do not dilute.

Application areas

Wound antiseptics:

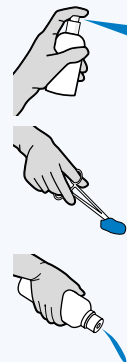
Treatment of acute, chronic, burn and surgical wounds.

Mucous membrane antiseptics:

Prior to diagnostic and surgical procedures in the ano- and urogenital region (e.g. before obliteration of haemorrhoids, before insertion of intrauterine devices or before pre-, intra- and postnatal manipulations), and in the oral cavity (e.g. before tooth extractions).

Prior to insertion of transurethral single-use or indwelling urinary catheters.

For preoperative skin antiseptics in areas adjacent to mucous membranes (e.g. before caesarean section).



octenilin® wound gel**



Key benefits

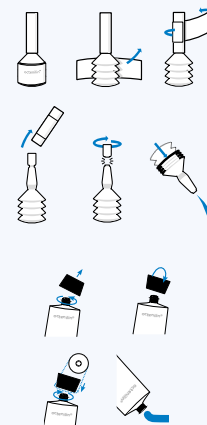
- Maintains a moist wound environment and supports the natural healing process
- Effectively cleanses the wound and loosens adherent debris/coatings
- Prevents bacterial growth within the gel
- Suitable for long-term and large-area applications
- Odour-absorbing
- Colourless and painless
- Sterile

Shelf life after opening: 6 weeks (20 ml); 8 weeks (250 ml).

Application areas

For **moisturising and cleansing** of acute and chronic wounds as well as for the management of burn wounds.

Improves scar quality when applied to the surgical wound immediately after closure.



octenilin® wound irrigation solution



Key benefits

- Excellent cleansing performance
- Very good tolerability
- Suitable for all wound situations
- Appropriate for repeated and long-term use
- Rapid elimination of unpleasant wound odour
- Suitable for combined use in negative pressure wound therapy with instillation (NPWT)
- In combination with the sterile schülke wound pad for quick and effective mechanical debridement
- Colourless and painless
- Sterile

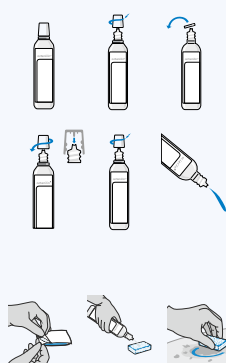
Shelf life after opening: 8 weeks

Application areas

For **rapid and effective wound cleansing**, e.g. for removal of wound crusts, necrotic tissue, microorganisms, biofilm and fibrin coatings. Also suitable for difficult-to-reach wound areas, such as fissures and wound pockets.

For **wound moisturising** and gentle removal of difficult-to-detach, encrusted dressings or wound coverings.

In combination with the sterile schülke wound pad for pain-reduced mechanical debridement as well as stimulation of local blood circulation and promotion of formation of new granulation tissue.



[schülke wound pad brochure.](#)

Optimal wound care workflow

The colourless formulation of octenidine-based products allows clear visibility of changes in the wound condition and enables precise documentation.



* If clinically indicated, obtain a wound swab or tissue sample (in this case, wound cleansing should be performed with Ringer's solution or a comparable irrigation fluid).

** The choice of secondary dressing must always be guided by the type and condition of the wound. With the exception of PVP-iodine-impregnated dressings, octenidine-containing products can be combined with all standard wound dressings. When using fatty gauze together with octenilin® wound gel, the dressing should be changed daily and the wound cleansed. octenilin® wound gel remains on the wound until the next dressing change. Dressing-change frequency depends on wound characteristics and the amount of exudate and should be adapted to the individual wound situation, but should not exceed a maximum interval of 3 days. In the event of an infected wound, the dressing should be changed daily. Combining octenidine with additional antimicrobial agents provides no further clinical benefit.

06 Effective mechanical debridement: schülke wound pads

Together with octenilin® wound irrigation solution, different grades of elastic, foamed polyurethane pads enable a tissue-friendly and pain-reduced debridement tailored to the individual wound condition.

According to European guidelines, debridement is an essential cornerstone of wound bed preparation that involves the removal of devitalised tissue, foreign material, micro-organisms and biofilm, as well as associated inflammatory mediators, in order to promote healing and prevent or treat infections. Unless contraindicated, debridement should be considered for all wounds and is particularly critical in hard-to-heal wounds with a high burden of necrotic tissue and slough that may impede the healing process. By restoring a viable wound bed, various methods of debridement may help to promote granulation and re-epithelialisation, attenuate local inflammation, and importantly, enhance the efficacy of subsequent topical therapeutic interventions.⁷⁵

Effective mechanical debridement at every dressing change can be detrimental, as scrubbing may disrupt fragile granulation tissue and damage newly formed capillaries. Owing to their different surface textures (fine-, medium- and coarse-pored) and permeability to liquids, the most appropriate

schülke wound pad can be selected according to the patient's individual wound characteristics, pain level and tolerance to achieve an optimal healing environment. The single-use, sterile pads allow for gentle debridement, stimulation of local blood circulation and promotion of new granulation tissue formation in the wound area, without any surgical intervention.

A recent comparative study demonstrated that regular debridement using the blue schülke wound pad in necrotic, exuding venous leg ulcers resulted in a significant reduction in patients' subjective pain perception over 30 days, as assessed by the Visual Analogue Scale (0 to 10; median decrease from 5.5 to 3). In contrast, conventional gauze debridement showed no meaningful pain relief (6.5 to 6). Patients also reported high satisfaction with the schülke wound pads, which is an essential factor for compliance and improved healing outcomes.⁹⁷

-  **White pad:** Fine-pored, smooth surface with partial liquid permeability
 - Enables gentle debridement
 - Ideal for removing soft wound coatings
-  **Blue pad:** Medium-pored, rough grid texture with moderate liquid permeability
 - Provides a moderately strong mechanical stimulus
 - Ideal for removing adherent/tough coatings
-  **Red pad:** Coarse-pored, rough surface with high liquid permeability
 - Delivers a strong mechanical stimulus
 - Suitable for deep wounds and for removing highly persistent, firm and/or necrotic coatings

octenilin® wound irrigation solution further supports gentle removal of coatings.



Debridement is a critical component of best practice in wound care due to its significant impact on the healing process.

07 Protection and intensive care for irritated skin: octenisept® protect & repair cream

The synergistic complex of panthenol, bisabolol, and octenidine strengthens the skin barrier and simultaneously helps to prevent infection and to diminish unpleasant odours.

The skin may be exposed to various, sometimes even significant external factors that compromise the integrity of the epidermis. As a result, essential protective functions can no longer be adequately maintained, leading to an increased risk of skin irritation, wounds and infection.

octenisept® protect & repair cream strengthens the natural skin barrier and protects stressed, dry and sensitive skin from external influences and moisture (e.g. wound exudate, urine, sweat), thereby helping to prevent skin irritation.⁹⁸ Thus, the cream is particularly suitable for intensive care settings and for patients with incontinence.

Free from any fragrances and colourants, octenisept® protect & repair cream is well tolerated by naturally sensitive skin and can be therefore used to soothe and protect against conditions such as diaper dermatitis in children from six months of age.⁹⁹

Strengthening the skin's integrity is not only important as a preventive measure. After wound closure, the newly formed epidermis also benefits from additional care. octenisept® protect & repair cream can be used in the follow-up management of various wound types (e.g. abrasions, minor cuts, superficial burns) to further promote ongoing skin regeneration. The cream is also well suitable for e.g. tattoo aftercare.

In professional settings, increased stress on the skin often leads to a higher risk of developing contact dermatitis. Frequent handwashing with soap and water, the use of low-quality hand disinfectants and prolonged wearing of personal protective equipment (e.g. gloves, face masks) can severely strain the skin, leaving it dry, cracked and flaky. octenisept® protect & repair cream can moisturise irritated areas, soothe the skin and help to restore its natural protective barrier.

+ Panthenol

Promotes skin regeneration and improves suppleness and elasticity

+ Bisabolol

Provides anti-inflammatory, soothing, caring and calming benefits

+ Octenidine

Inhibits odour-causing microorganisms

Dermatologically tested in children from six months of age.⁹⁹



Skin integrity is central to overall health. As the body's primary protective barrier, it must be preserved against mechanical, chemical and biological challenges.

08 schülke: Your trusted partner in advanced wound care

Our octenidine-based products provide targeted support across all phases of wound healing – from effective cleansing, debridement and disinfection to moisturisation, promotion of healing, tissue regeneration and skin care.

Phase of wound healing	Local intervention	Product*
Phase 1: Haemostasis & Inflammation	Cleansing	octenilin® wound irrigation solution
	Debridement	schülke wound pad
	Disinfection	octenisept®
	Moisturisation	octenilin® wound gel octenisept® gel
Phase 2: Proliferation	Cleansing	octenilin® wound irrigation solution
	Disinfection	octenisept®
	Moisturisation	octenilin® wound gel octenisept® gel
Phase 3: Re-epithelialisation	Moisturisation & promotion of wound healing	octenilin® wound gel octenisept® gel
Phase 4: Remodelling	Protection & care	octenisept® protect & repair cream

* Indications and labels are according to the Austrian registration of the corresponding products and may differ in other countries. Please consider respective SmPC/product information for further information.

09 Translating scientific evidence into practice: Clinical case reports

Case 1 | Hard-to-heal wound

Patient

70-year-old female

Clinical presentation

Venous leg ulcer on the right lateral malleolus

Medical history

- Chronic venous insufficiency
- Compression therapy (compression stockings)
- Wound present for one year at the time of admission
- Prior treatment with foam dressings

Wound care with octenidine

Cleansing with octenilin® wound irrigation solution and treatment with octenilin® wound gel

Treatment time with octenidine

42 days

Secondary wound dressings

Non-adherent wound contact layer, non-woven gauze

Day 1



© Assadian et al, Journal of Wound Care 2016

Day 34



Day 42



Case 2 | Mechanical debridement

Patient

64-year-old male

Clinical presentation

Postthrombotic ulcer on the medial aspect of the left lower leg with mildly sloughy fibrin strands

Medical history

- Painful sharp surgical debridement using a Volkmann bone curette
- High pain sensitivity of the patient

Wound care with octenidine

- Mechanical debridement using schülke wound pads combined with

octenilin® wound irrigation solution, resulting in a clean wound bed ready for split-thickness skin grafting

- Debris and fibrin stuck well to the schülke wound pads, preserving vital tissue

Treatment time with octenidine

2 minutes

Before



After



© Assadian et al, Journal of Wound Care 2016

Case 3 | Hard-to-heal wound

Patient

41-year-old male

Clinical presentation

Stage III sacral pressure ulcer (7x6.5x1 cm)

Medical history

- Initial treatment with sodium-hypochlorite (NaOCl)-based solution, carboxymethyl-cellulose-based hydrogel
- Multiple (surgical) debridement procedures

Wound care with octenidine

- Treatment of the periwound skin with **octenisan® wash lotion**
- Debridement with gauze soaked in **octenilin® wound irrigation solution**
- Treatment of the wound with **octenisept® gel***
- Care of the periwound skin with **octenisept® protect & repair cream**
- Dressing changes every two days

Treatment time with octenidine

187 days

Secondary wound dressings

Gauze, gamgee pad, transparent plaster

Day 1



Day 88



Day 187



© Dr. Evelyn Hoh YL., Department of Surgery, Hospital Sultan Abdul Aziz Shah, University Putra Malaysia | Schülke & Mayr (Asia) Pte Ltd, Singapore
*octenilin® wound gel may be used as an equivalent sterile treatment option.

Case 4 | Hard-to-heal wound

Patient

85-year-old female

Clinical presentation

Stage IV sacral pressure ulcer containing necrotic tissue

Wound care with octenidine

Gauze soaked with **octenilin® wound irrigation solution**, changed up to 3 times daily for 244 days

Treatment time with octenidine

244 days

Secondary wound dressing

Gauze

Day 1



Day 48



Day 244



© Schülke & Mayr GmbH, Vienna, Austria

Case 5 | Hard-to-heal wound

Patient

60-year-old male

Clinical presentation

Highly exudative diabetic foot ulcer (5x5 cm) on the right heel, infected with *Enterobacter spp.*

Medical history

- Type 2 diabetes mellitus
- Hypertension
- Dyslipidemia
- Antibiotic therapy

Wound care with octenidine

- Debridement of devitalised tissue with a curette, followed by mechanical debridement with an **octenisept®**-soaked gauze
- Cleansing and disinfection with **octenisept®**

Treatment time with octenidine

6 weeks

Secondary wound dressings

Foam dressing, cotton padding, compression bandages

Day 1



Week 3



Week 6



© Tongson, Journal of Wound Care 2025

Case 6 | Hard-to-heal wound

Patient

78-year-old male

Clinical presentation

Diabetic foot ulcer with diabetic gangrene and osteolysis of the second toe, accompanied by severe infection and necrosis of the hallux

Medical history

- Type 2 diabetes mellitus
- Diabetic neuropathy
- Upon admission:** Amputation of the second toe and surgical debridement of the hallux

Wound care with octenidine

- octenilin® wound gel**, with dressing changes every 2–3 days
- No antibiotic therapy

Treatment time with octenidine

21 days

Secondary wound dressing

Foam dressing

Before amputation



Day 1



Day 21



© Assadian et al., Journal of Wound Care 2016

Case 7 | Hard-to-heal wound

Patient

63-year-old male

Clinical presentation

Exudative hard-to-heal surgical wound on the medial aspect of the right foot, following first-ray amputation due to *S. pyogenes* bacteraemia

Medical history

- Type 2 diabetes mellitus
- Hypertension with likely hypertensive cardiomyopathy
- Stage 5 chronic kidney disease approaching end-stage renal failure
- Capillaritis/small-vessel vasculitis
- Non-ST-elevation myocardial infarction
- Normocytic normochromic anaemia
- Antibiotic therapy

Wound care with octenidine

Cleansing and disinfection with **octenisept®**-soaked gauze for 1 minute, followed by conservative sharp debridement, with dressing changes every other day

Treatment time with octenidine

6 weeks

Secondary wound dressings

Silver hydrofiber dressing, foam dressing

Day 1



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Week 2



Week 6



Case 9 | Negative pressure wound therapy with instillation (NPWTi)

Patient

74-year-old male

Clinical presentation

Stage IV gluteal pressure ulcer associated with group B beta-haemolytic streptococcal infection

Medical history

Post-traumatic paraplegia of the lower extremities persisting for 46 years

Wound care with octenidine

- Day 1: Surgical debridement and wound bed conditioning using V.A.C. Ultra™ with **octenilin® wound irrigation solution**
- Days 1–5: Instillation with **octenilin® wound irrigation solution** for 3 minutes every 12 hours

- Day 6: Surgical wound closure by local flap coverage; daily disinfection with **octenisept®** until complete re-epithelialisation

NPWTi with octenidine

5 days

Day 1



© Matiassek et al., Journal of Wound Care 2014

Day 5



Day 90 after surgery



Case 8 | Hard-to-heal wound

Patient

71-year-old female

Clinical presentation

Diabetic foot syndrome

Medical history

- Type 2 diabetes mellitus
- Hypertension

- Atherosclerosis
- Dyslipidemia
- Hyperglycaemia
- Endovascular angioplasty
- Infected Wagner grade 4 ulcer on the forefoot (multidrug-resistant *P. aeruginosa*, *K. pneumoniae*)
- Diabetic gangrene affecting the first to fourth toes
- Amputation of the gangrenous toes

Wound care with octenidine

Gauze soaked with **octenisept®**, with dressing changes every 2–3 days

Treatment time with octenidine

42 days

Secondary wound dressing

Gauze

Day 1



© Assadian et al., Journal of Wound Care 2016

Day 14



Day 42



Palliative wound care

The recent *European Wound Management Association* 2025 guideline underscores that in palliative wound management, the primary aim shifts from rapid and aesthetically pleasing healing to alleviating distressing clinical symptoms such as pain, odour, exudate, bleeding and itching.¹⁰⁰

By defining palliative wound care as “*person- and family-centred, holistic and interdisciplinary care of wounds that may heal, or not, or may be too onerous to treat; including but not limited to symptom control and management, for individuals who are often vulnerable and have impaired quality of life*”,¹⁰¹ the document further emphasises the need for adjustments in clinical structures and a change in professional mindset. Such a holistic, person-centred approach to palliative wound care reflects its multifaceted nature, addressing not only the physical aspects of wound management but also the emotional and social dimensions of the experiences of both patients and caregivers.

In that context, **neoplastic ulcers** in particular represent an enormous physical and psychological burden for affected patients and family members. Integrating appropriate wound management into end-of-life care planning poses a significant and time-consuming clinical challenge. As a local intervention, octenidine-based products have been shown not only to improve the clinical condition of neoplastic ulcerations, but also to have a positive impact on the patients’ overall well-being and quality of life.^{102,103}

Case 10 | Postoperative wound with delayed healing

Patient

57-year-old male

Clinical presentation

Surgical site complication at the radial artery harvest site of the left forearm following coronary artery bypass grafting

Medical history

- Type 2 diabetes mellitus
- Severe obesity
- Initial wound care with PVP-iodine spray and dry gauze

- **Day 16:** Pronounced erythema and wound dehiscence; systemic antibiotic therapy due to *S. aureus* wound infection until day 35
- **Days 35–38:** Treatment with silver-impregnated hydrofiber dressing
- **Days 39–40:** Treatment with medical honey and Mepilex® Ag foam dressing with silver and soft silicone

Wound care with octenidine

- **Days 41–48:** Treatment with **octenilin® wound gel** and Mepilex® Ag foam dressing with silver and soft silicone

- **Day 49:** Reduced dehiscence and erythema; continued treatment with **octenilin® wound gel** covered with a polyurethane film dressing and gauze until complete wound closure on day 62

Treatment time with octenidine

22 days

Secondary wound dressings

Gauze, polyurethane film dressing, silver-impregnated hydrofiber dressing, Mepilex® Ag foam dressing with silver and soft silicone

Day 16



Day 35



Day 62



© Assadian et al., Journal of Wound Care 2016

Case 11 | Postoperative wound with delayed healing

Patient

23-year-old male

Clinical presentation

Surgical site complication following excision of a pilonidal sinus

Medical history

Pilonidal sinus excised and closed primarily three years ago

Wound care with octenidine

- **Days 1–20:** Daily cleansing with **octenilin® wound irrigation solution**
- **Days 21–49:** Disinfection with **octenisept®**, applied 2–3 times daily

Treatment time with octenidine

49 days

Secondary wound dressings

Hemostyptics agent, absorbent compresses for dressing closure

Day 4



Day 24



Day 90



© Schülke & Mayr GmbH, Vienna, Austria

Case 12 | Postoperative wound with delayed healing

Patient

64-year-old female

Clinical presentation

Surgical site complication following skin-sparing mastectomy for breast carcinoma, including intraoperative implant-based reconstruction of the right breast

Medical history

- Adverse reaction to silver-based dressings
- Initial wound coverage with cotton gauze
- Postoperative day 7: Development of local edema and secondary tissue tension
- Postoperative day 10: Pronounced erythema and necrosis in the surgical area

Wound care with octenidine

- **Days 1–71:** Cleansing with **octenilin® wound irrigation solution** and treatment with **octenilin® wound gel**, with dressing changes every 3 days during the first 4 weeks, then every 4–5 days

- **Day 7:** Significant reduction of necrotic tissue and local signs of infection
- No antibiotic therapy

Treatment time with octenidine

71 days

Secondary wound dressings

Fibrous absorbent compresses (for high exudation), silicone wound contact layer, Mepilex® Border Flex foam dressing

Day 1



Day 7



Day 71



© Schülke & Mayr GmbH, Vienna, Austria

Case 13 | Postoperative wound with delayed healing

Patient

68-year-old male

Clinical presentation

Surgical site complication following plate osteosynthesis of the right lateral malleolus

Medical history

Cerebral infarction

Wound care with octenidine

- **Days 1–42:** Debridement and subsequent disinfection with **octenisept®**
- Oral antibiotic therapy and consistent elevation of the affected limb
- Exudate management using an antimicrobial wound dressing

- **From day 43:** Wound irrigation with Ringer's solution and exudate management with a superabsorbent foam dressing

Treatment time with octenidine

43 days

Secondary wound dressing

Superabsorbent foam dressing

Day 1



Day 43



Day 54



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Case 14 | Pre-, intra- and postoperative wound antisepsis

Patient

4-year-old male child

Clinical presentation

Contaminated skin and soft tissue defect in the facial region following a dog bite

Day 1



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Wound care with octenidine

- Pre-, intra- and postoperative antisepsis with **octenisept®**
- Debridement and systemic antibiotic therapy
- Drain removal on the following day

Day 7



Treatment time with octenidine

6 days

Secondary wound dressings

Sterile wound closure strips, adhesive dressing

Day 30



Case 15 | Pre-, intra- and postoperative wound antisepsis

Patient

30-year-old male

Clinical presentation

Traumatic avulsion of the cranial portion of the right auricle

Day 1



© Fiedler et al., Laryngo-Rhino-Otologie 2025

Wound care with octenidine

- **Day 1:** Disinfection of the wounded scalp area using **octenisept®**; spray disinfection of the amputated auricle with **octenisept®** followed by denudation and implantation into an interfascial pocket to ensure adequate nutrient supply; prior to readaptation, immersion of the cartilage in sodium chloride for 10 seconds and subsequent spray disinfection with **octenisept®**; surgical closure of the auricular stump after repeated disinfection with **octenisept®**

After 3 months



After 6 months



Case 16 | Fish skin grafting (Kerecis®)

Patient

86-year-old female

Clinical presentation

Complex defect (6x4 cm) on the frontal bone surface after failure of full-thickness skin grafting due to multiple resections of a basal cell carcinoma (EADO stage IIA, R0 resection)

Medical history

- Hypertension, atrial fibrillation, cardiac pacemaker

- Macular degeneration
- Degenerated full-thickness skin graft

Wound care with octenidine

- **Day 1:** Intraoperative disinfection of the wound bed with **octenisept®** followed by application of fish skin graft (Kerecis® Omega3 Wound) and **octenilin® wound gel**; wound coverage with a non-adherent contact layer and a saline-soaked gauze, followed by fixation with compresses
- **Days 2–7:** Daily disinfection with **octenisept®**, treatment with **octenilin® wound gel**, wound coverage

with a non-adherent contact layer and a saline-soaked gauze; final fixation with compresses

- **Days 8–32:** Dressing changes every 2–5 days as described above until complete re-epithelialisation of the defect

Treatment time with octenidine

32 days

Secondary wound dressings

Adaptic™ Touch non-adherent silicone wound contact layer, gauze, compresses



Before fish skin grafting



© Fiedler et al., International Wound Journal 2025

Day 1



After 6 weeks



Case 17 | Fish skin grafting (Kerecis®)

Patient

62-year-old male

Clinical presentation

Extensive skin necrosis in the right pectoral region after removal of a MSSA-infected port catheter

Medical history

- Resection of a p16-positive squamous cell carcinoma of the oral cavity followed by
- radiochemotherapy with cisplatin
- Septic shock resulting from a port infection with MSSA, complicated by bilateral pneumonia with septic microemboli, disseminated intravascular coagulation,

acute kidney and liver failure and delirium secondary to septic encephalopathy

- Extensive right pectoral skin necrosis approx. 2 weeks post port removal

Wound care with octenidine

- **Day 1:** Surgical debridement and intraoperative disinfection of the wound bed with **octenisept®**, followed by application of intact as well as fragmented fish skin graft (Kerecis® Omega3 Wound) and **octenilin® wound gel**; wound coverage with a non-adherent contact layer and a saline-soaked gauze, followed by fixation with compresses
- **Days 2–7:** Daily spray disinfection with **octenisept®** and application of

octenilin® wound gel, wound coverage with a non-adherent wound contact layer and a saline-soaked gauze, followed by fixation with compresses

- **Day 4:** Complete formation of granulation tissue
- **From day 8:** Dressing changes every 3–7 days as described above until complete re-epithelialisation

Treatment time with octenidine

4 months

Secondary wound dressings

Adaptic™ Touch non-adherent silicone wound contact layer, gauze, compresses



Before fish skin grafting



© Dr. L. Fiedler, MBA, SLK-Kliniken Heilbronn GmbH, Germany | Schülke & Mayr GmbH, Vienna, Austria

Day 1



After 4 months



Case 18 | Split-thickness skin grafting

Patient

87-year-old female

Clinical presentation

Pretibial haematoma causing skin necrosis on the right leg

Medical history

- Type 2 diabetes mellitus
- Class I obesity
- Heavy tobacco use
- Rheumatoid arthritis
- Chronic renal insufficiency
- Right heart failure

- Recurrent deep vein thrombosis
- Long-term oral cortisone therapy
- 4-week treatment with a PVP-iodine-based wound gel

Wound care with octenidine

- Day 1: Intraoperative disinfection of the wound bed with octenisept®; debridement and rinsing again with octenisept®; bathing the split-thickness skin graft in octenisept® for 30 seconds; transplantation of the skin graft and application of a tie-over dressing consisting of foam and compresses moistened with octenisept® for 5 days

- Days 5–14: Disinfection with octenisept® at each dressing change
- Days 15–21: Care with dexpanthenol cream

Treatment time with octenidine

14 days

Secondary wound dressings

Foam dressing, compresses, paraffin gauze

Before skin grafting



Day 1



Day 35



© Matusiek et al., Journal of Wound Care 2015

Case 19 | Acute bacterial skin and soft tissue infection

Patient

63-year-old male

Clinical presentation

Moderately exuding carbuncle (4x4cm) located in the right occipital region

Medical history

- Type 2 diabetes mellitus
- Hypertension
- End-stage renal failure
- Ischaemic heart disease

- Initial treatment with enzymatic dressing and foam dressing
- Incision and drainage

Wound care with octenidine

- Treatment of the periwound skin with octenisept® wash lotion
- Wound cleansing and disinfection with octenisept®, followed by application of gauze soaked with octenilin® wound irrigation solution
- Treatment of the wound with octenisept® gel*

- Care of the periwound skin with octenisept® protect & repair cream
- Dressing changes twice weekly

Treatment time with octenidine

28 days

Secondary wound dressings

Gauze, Melonin® low-adherent absorbent dressing

Day 1



Day 25



Day 46



© Prof. Hari Krishna K. R. Nair, Wound Care Unit, Hospital Kuala Lumpur, Malaysia | Schülke & Mayr (Asia) Pte Ltd, Singapore
*octenilin® wound gel may be used as an equivalent sterile treatment option.

Case 20 | Cutaneous Leishmaniasis

Patient

44-year-old male

Clinical presentation

Leishmania infantum-infected ulcerative facial skin lesion (2x2cm) on the left cheek, with crusting, peripheral erythema, localised swelling, pruritus and skin tightness

Medical history

- Seafarer working on a rotational schedule
- Six months prior to lesion onset: stay on the Mexican coast and a Croatian island
- Initial treatment with 1g amoxicillin/

clavulanic acid twice daily for 10 days without clinical improvement

- Identification of *L. infantum* from presenting skin lesion through direct microscopy and PCR testing
- Day 1: Intradermal administration of 10mg (2ml) meglumine antimoniate (Glucantime®) into the edges of the lesion, every three days for a total of five sessions

Wound care with octenidine

- Days 1–94: In parallel to the local anti-protozoal therapy with Glucantime®, daily cleansing and disinfection with

- octenisept®-soaked gauze (left in contact with the lesion for 10 minutes), followed by treatment with octenilin® wound gel
- Days 95–146: Complete re-epithelialisation; 2–3 times daily application of octenisept® protect & repair cream to support skin care and regeneration

Treatment time with octenidine

146 days

Secondary wound dressing

Vivapore® hydrophobic polyurethane foam

Day 1



Day 94



Day 146



© D. Ledina et al., poster presentation @ Croatian Congress of Clinical Microbiology and Infectious Diseases 2025

Case 21 | Cutaneous fungal infection

Patient

30-year-old male

Clinical presentation

Ulcerative, thick hyperkeratotic plaque with haemorrhagic crusts on the lower face, infected with *Annulohyphoxylon* spp. and presenting with a weeping, slough-covered, malodorous wound surface

Medical history

- Woodcutter
- Initially presenting as a single papule, the lesion gradually enlarged, coalescing into a painful and pruritic plaque
- Clinically septic on admission: severe pain, fever, deranged laboratory values, local perivascular inflammation
- Systemic antifungal therapy

Wound care with octenidine

- Initial sharp surgical debridement using a No. 11 blade
- Cleansing with octenilin® wound irrigation solution followed by disinfection with octenisept®
- Dressing changes every 3 days for 2 weeks

Treatment time with octenidine

14 days

Secondary wound dressing

Oxymax® silver alginate dressing

Day 1



Day 17



© Dr. Elizabeth Chang W.H., Department of Dermatology, Hospital Selayang, Malaysia | Schülke & Mayr (Asia) Pte Ltd, Singapore

Case 22 | Superinfected wound caused by (drug-resistant) bacteria

Patient

73-year-old male

Clinical presentation

Surgical site infection on the left lower leg following split-thickness skin grafting (12x8.5cm), with necrotic tracts and superinfection caused by ESK, MRSA, *P. vulgaris*, *P. aeruginosa* and *E. faecalis*

Medical history

- Diabetes mellitus type 2
- Initial excision of a squamous cell carcinoma on the left lower leg, followed by split-thickness skin grafting
- Local signs of infection 6 days later
- Treatment with medical honey and a gauze dressing for 10 days

Wound care with octenidine

- Days 1–25: Cleansing and disinfection with octenisept® followed by application of octenilin® wound gel, with daily dressing

changes for the first 5 days, then every other day

- Days 1–5: Daily whole-body decolonisation using octenisan® md nasal gel and octenisan® wash lotion to reduce the risk of recontamination
- No antibiotic therapy

Treatment time with octenidine

24 days

Secondary wound dressings

Gauze, hydrofiber dressing



Day 1



Day 5



Day 24



© Matussek et al., Biomed Journal of Scientific & Technical Research 2018

Case 23 | Acute inflammatory skin infection

Patient

45-year-old female

Clinical presentation

Bullous erysipelas with blistering on the left lower leg caused by group A beta-haemolytic streptococci

Medical history

- Diabetes mellitus type 2
- Severe obesity (adipositas permagna)
- Disease progression despite systemic antibiotic therapy; amputation was considered

Wound care with octenidine

Debridement using the VERSAJET® hydro-surgery system, followed by daily disinfection with octenisept®-soaked compresses

Treatment time with octenidine

10 days

Secondary wound dressing

Compresses

Day 1



Day 5



Day 21



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Case 24 | Superinfected haemorrhagic skin lesions

Patient

15-year-old male adolescent

Clinical presentation

Meningococcal septicaemia with large skin necroses and superinfection involving *S. aureus*, *P. aeruginosa* and *Candida spp.* on the arms and legs

Medical history

- Circulatory dysregulation due to septic vasoplegia
- Adult respiratory distress syndrome

- Acute kidney injury
- High-dose systemic analgesic and antibiotic therapy
- Surgical debridement

Wound care with octenidine

- Days 1–4: Daily disinfection of skin lesions with octenisept® and application of octenilin® wound gel for wound bed preparation prior to split-thickness skin grafting on day 5

- Days 5–23: Ongoing treatment of remaining wounds with octenilin® wound gel, which progressively facilitated dressing changes every two days, resulting in reduced pain and decreased analgesic requirements

Treatment time with octenidine

23 days

Secondary wound dressings

Superabsorbent dressing, sterile ES-compresses (after exudation subsided)

Day 1



Day 1



Day 42



© Hintner and Schmid, Wundmanagement 2010 (article in German)

Case 25 | Necrotising fasciitis

Patient

24-year-old male

Clinical presentation

Necrotising fasciitis (10x6cm) involving the anterior cervical region

Medical history

- Fracture of the right lower molar tooth
- Progressive swelling of the right submandibular region with extension to the left submandibular area, the anterior neck and the chest wall

- Painful swelling on palpation
- Foul-smelling purulent discharge from the oral cavity
- Marked halitosis
- Antibiotic therapy for 5 days followed by incision and drainage
- Initial treatment with PVP-iodine, saline and paraffin dressing

Wound care with octenidine

- Initial sharp debridement
- Until week 8: Wound cleansing with octenilin® wound irrigation solution and

application of octenisept® gel*, with daily dressing changes

- Weeks 9–12: Daily treatment with octenisept® gel*

Treatment time with octenidine

12 weeks

Secondary wound dressings

Gauze, Melonin® low-adherent absorbent dressing

Day 1



After 6 weeks



After 12 weeks



© Dr. Mohamad Helmi M. R., Wound Care Unit, Hospital Ampang, Malaysia | Schülke & Mayr (Asia) Pte Ltd, Singapore
*octenilin® wound gel may be used as an equivalent sterile treatment option.

Case 26 | Chronic inflammatory skin disease with acute bacterial superinfection

Patient

3-year-old female toddler

Clinical presentation

Atopic dermatitis with impetigo contagiosa (bullous impetigo) on the right arm

Wound care with octenidine

- Intensive care of non-infected skin areas with professional skincare products
- Treatment of infected skin lesions with a topical corticosteroid (mometasone ointment) and **octenilin® wound gel***, applied three times daily

Treatment time with octenidine

5 days

Secondary wound dressing

Tubifast® Garments tubular bandages

Day 1



Day 4



Day 5



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* octenisept® gel may be used as an equivalent non-sterile treatment option.

Case 27 | Acute superficial bacterial skin infection

Patient

3-year-old female toddler

Clinical presentation

Impetigo vulgaris (non-bullous impetigo) in the area of the left oral commissure

Wound care with octenidine

- Days 1–6: Several times daily disinfection with **octenisept®** and treatment with **octenisept® gel**
- No antibiotic therapy

Treatment time with octenidine

6 days

Day 1



Day 3



Day 6



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Case 28 | Dystrophic epidermolysis bullosa

Patient

7-year-old female child

Clinical presentation

Accidental skin detachment on the thumb

Medical history

- Dystrophic epidermolysis bullosa (rare inherited skin disorder)
- Excessive skin fragility upon minor trauma

Wound care with octenidine

Cleansing with **octenilin® wound irrigation solution**

Treatment time with octenidine

7 days

Secondary wound dressing

Fatty gauze

Day 1



Day 7



After 6 months



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Case 29 | Acute abrasion

Patient

9-year-old female child

Clinical presentation

Acute abrasion following a fall onto asphalt

Medical history

- Initial treatment with a hydrocolloid dressing (Varihesive® extra thin) for the first 4 days
- Dressing was removed due to strong odour formation and edge detachment
- Local signs of infection

Wound care with octenidine

- Days 1–6: Daily disinfection with **octenisept®** and treatment with **octenisept® gel**
- Days 7–15: Daily care of already re-epithelialised areas with **octenisept® protect & repair cream**; remaining wound areas continue to be treated with **octenisept® gel**
- From day 16: Care of the entire wound area with **octenisept® protect & repair cream** (once daily in the evening, without secondary dressing) until visible healing

Treatment time with octenidine

16 days (plus **octenisept® protect & repair cream** for approximately 3 weeks)

Secondary wound dressing

Hansaplast classic fabric plaster

Day 1



Day 7



Day 40



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Case 30 | Acute thermal burn

Patient

69-year-old female

Clinical presentation

Second-degree (Grade 2a) thermal burn injury on the ventral side of the left forearm, caused by contact with a hot baking tray

Medical history

Immediate cooling of the wound under cold running water for several minutes

Wound care with octenidine

octenisept® gel, with dressing changes every 2–3 days

Treatment time with octenidine

33 days

Secondary wound dressings

Mepilex® XT soft silicone foam dressing, elastic gauze bandages

Day 1



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Day 15



Day 43



Case 32 | Acute thermal burn

Patient

75-year-old male

Clinical presentation

Second-degree thermal burn injury to the left index and middle fingers, caused by boiling water

Medical history

Type 2 diabetes mellitus

Wound care with octenidine

- Days 1–3: Daily dressing changes including mechanical debridement, wound cleansing using octenilin® wound irrigation solution and disinfection with octenisept®
- Days 4–6: Daily wound cleansing with octenilin® wound irrigation solution, disinfection with octenisept® and treatment with octenilin® wound gel* (without secondary dressing)

- Days 7–23: Disinfection with octenisept®, and treatment with octenilin® wound gel*, several times daily without secondary dressing
- No antibiotic therapy

Treatment time with octenidine

23 days

Secondary wound dressings

Gauze, compresses

Day 1



Day 7



Day 23



© M. Karadzic, e-poster presentation @ European Wound Management Association Conference 2025 (EP0747; Journal of Wound Care 2025)
* octenisept® gel may be used as an equivalent non-sterile treatment option.

Case 31 | Acute thermal burn

Patient

10-year-old female child

Clinical presentation

Second-degree (Grade 2b) thermal burn injury on the ventral side of the right forearm, caused by contact with a hot toaster

Wound care with octenidine

- Days 1–6: 2–3 times daily disinfection with octenisept®, followed by application of octenisept® gel
- Days 7–15: Twice daily care of already re-epithelialised areas with octenisept® protect & repair cream; remaining wound areas continue to be treated with octenisept® gel
- From day 16: Multiple daily applications of octenisept® protect & repair cream to the entire wound area until visible healing

Treatment time with octenidine

16 days (plus octenisept® protect & repair cream for 2–3 weeks)

Secondary wound dressing

Hansaplast classic fabric plaster

Day 1



© Schülke & Mayr GmbH, Vienna, Austria

Day 7



Day 21



Case 33 | Acute thermal burn

Patient

18-year-old male

Clinical presentation

Severe second-degree (Grade 2a/2b) thermal burn injury affecting 82% total body surface area, caused by a flash explosion from an aerosolised room spray; Grade 1 inhalation trauma

Wound care with octenidine

- Day 1: Application of epicite^{hydro} face mask, pre-soaked in octenisept® for 20 minutes; the moistened mask remains on the patient's face for 14 days without further manipulation
- Day 14: Gently removal of small residual fragments of the face mask
- Day 20: Nearly complete re-epithelialisation

- Day 43: Complete healing of the facial area

Treatment time with octenidine

14 days

Secondary wound dressing

epicite^{hydro} face mask

Day 1



Day 14



Day 43



© Prof. F. Siemers und Dr. I. Nietzschmann, Verbrennungszentrum BG Klinikum Bergmannstrost Halle/Saale, Germany | Schülke & Mayr GmbH, Vienna, Austria

Case 34 | Acute thermal burn

Patient

2-year-old female toddler

Clinical presentation

Extensive flame-induced thermal burn injury (Grade 2a/2b, with areas of partial Grade 3 involvement) affecting 45% total body surface area; thermal inhalation injury

Medical history

- Immediate systemic antibiotic and anti-fungal therapy; local treatment with 10% PVP-iodine and 0.3% chlorhexidine
- Xenografting (pig skin, 600 cm²) on day 3
- Very poor general condition on day 15

Wound care with octenidine

- Day 1: Removal of the xenograft and initiation of local therapy with gauze soaked in octenisept® (8–10 layers), dressing changes every 2 days

- Day 3: Marked improvement in the patient's general condition, with visible island-like re-epithelialisation of the wound area
- Day 5: Autologous split-thickness skin grafting and continued dressing changes every 2 days with octenisept®-soaked gauze; normalised haematological parameters
- Day 23: Complete re-epithelialisation

Treatment time with octenidine

23 days

Secondary wound dressings

Gauze, Grassolind® paraffin gauze, Omiderm® artificial skin dressing

Day 1



Day 3



Day 23



© Dr. S. Smirny, City Hospital No. 3/Department of Thermal Injury, Nikolaev, Ukraine | Schülke & Mayr GmbH, Vienna, Austria

Case 35 | Acute thermal burn

Patient

48-year-old male

Clinical presentation

Second-degree (Grade 2b) thermal burn injury on the left forearm

Medical history

- Two-week treatment with fatty gauze
- Crusted coating over the entire forearm

Wound care with octenidine

Treatment with octenilin® wound gel, with dressing changes every 2 days

Treatment time with octenidine

14 days

Secondary wound dressing

Foam dressing

Day 1



Day 14



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Case 36 | Radiation-induced skin injury

Patient

male

Clinical presentation

Radiation-induced skin injury in the head and neck region involving ulceration

Wound care with octenidine

octenilin® wound gel, with daily dressing changes

Treatment time with octenidine

12 days

Secondary wound dressing

Film dressing

Day 1



Day 12



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Case 37 | Sunburn

Patient

12-year-old female child

Clinical presentation

Painful first-degree sunburn on the left shoulder

Wound care with octenidine

- Day 1: Treatment with octenisept® gel, applied once in the afternoon and once in the evening without secondary dressing
- Immediate cooling and antipruritic effect

Treatment time with octenidine

1 day

Day 1



Day 2



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Case 38 | Umbilical cord care

Patient

4-day-old female neonate
(born at 41+6 weeks of gestation)

Clinical presentation

Inflamed umbilical stump

Medical history

- Severance of the umbilical cord after birth using a clamp
- Removal of the umbilical clamp on postpartum day 3
- Signs of inflammation with redness, mild swelling and moisture around the umbilical area on postpartum day 4

Wound care with octenidine

- 2–3 times daily disinfection of the umbilical area with **octenisept®**
- No additional wound dressings
- Fastening the diaper below the umbilical stump to prevent irritation

Treatment time with octenidine

4 days

Day 1



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Day 2



Day 4



Case 40 | Acute inflammatory skin disease

Patient

6-month-old male infant

Clinical presentation

Diaper dermatitis following RSV infection

Wound care with octenidine

- Regular and gentle cleansing of the diaper area using soft baby wipes
- After each cleansing, treatment with **octenisept® gel** (several times daily)

Treatment time with octenidine

4 days

Day 1



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Day 2



Day 4



Case 39 | Inflamed sore nipple

Patient

38-year-old female

Clinical presentation

Inflamed sore nipple caused by regular breastfeeding

Medical history

Erythema, swelling, skin fissures, pronounced tenderness, burning sensation

Wound care with octenidine

- Several times daily disinfection with **octenisept®** and treatment with **octenisept® gel**

- Gently removal of any residual gel with warm water immediately before breast-feeding
- No additional wound dressings or nursing pads; no bra
- Maintenance of the normal breastfeeding routine

Treatment time with octenidine

5 days

Day 1



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Day 3



Day 5



Case 41 | Incontinence-associated dermatitis

Patient

72-year-old female

Clinical presentation

Incontinence-associated dermatitis

Medical history

- Severe obesity, multiple comorbidities
- Known adhesive allergy
- Urinary and faecal incontinence
- Bed-confined due to limited mobility
- The wound has been present for 16 months, showing marked signs of inflammation and infection

- Previous topical treatments included Candibene® cream, Travocort® cream and local antibiotics

Wound care with octenidine

- **Days 1–64:** Daily disinfection with **octenisept®**, treatment with **octenilin® wound gel**, and protection of the wound margins using **octenisept® protect & repair cream**
- **From day 64:** Continued regular skin care and skin protection with **octenisept® protect & repair cream**
- No antibiotic or antifungal therapy

Treatment time with octenidine

64 days (plus ongoing regular skin care with **octenisept® protect & repair cream**)

Secondary wound dressing

Self-adherent foam dressing without adhesive border



Day 1



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Day 64



After 1 year



Case 42 | Peristomal skin complication

Patient

42-year-old female

Clinical presentation

Damaged skin around an ileostomy

Medical history

- Chronic gastritis, cervical cancer, hyperthyroidism
- Ileostomy for 30 days as a result of perforation of the small intestine
- Flat two-piece ostomy system (base plate and detachable pouch)

- Stoma care routine: Washing the peristomal skin with mild soap including thoroughly drying
- Use of stoma paste and powder to aid the base plate stick if the peristomal skin is damaged or moist
- Upon admission:** Erosion, ulceration and redness of the peristomal skin, resulting in bleeding, pain and a burning sensation; base plate too large for the stoma; extreme dissatisfaction of the patient with her quality of life

Wound care with octenidine

- Days 1 and 3 (inpatient setting):** Cleansing and disinfection of the peristomal skin with **octenisept®**, followed by application of a stoma paste, a moisture-retentive hydrocolloid dressing and an appliance base plate with an appropriate opening
- Day 3:** Almost complete healing of the peristomal skin
- Outpatient setting:** During each base plate change (every 2–3 days), cleansing and disinfection of the peristomal skin with **octenisept®**; regular care of the peristomal area; no application of a hydrocolloid dressing
- Significant increase in the patient's quality of life
- High patient satisfaction with the treatment course

Treatment time with octenidine

28 days

Secondary wound dressing

Hydrocolloid dressing



Day 1



Day 28



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Case 43 | Peristomal skin complication

Patient

50-year-old male

Clinical presentation

Damaged skin around an ileostomy

Medical history

- Ileostomy for 15 months as a result of a tumour resection in the proximal transverse colon
- Parastomal hernia; high-output stoma with loose effluent
- High-output stoma appliance, with adhesive remover, stoma seals, elastic tape and flange extenders

- Lynch syndrome; autism; learning disabilities; obsessive-compulsive disorder; minimal capacity for communication
- Intermittent peristomal skin complications with poor adherence to treatment options
- Previous treatments with barrier wipes and spray, Manuka honey, antimicrobial emollient skin wash
- Upon admission:** Erythema, excoriation, inflammation and weeping, extending in a 5 cm radius around the stoma; signs of moisture-associated skin damage and medical-adhesive related skin injury; moderate to severe pain

Wound care with octenidine

- Days 1–21:** Immediately before changing the appliance (usually every other day), cleansing of the peristomal skin with gauze soaked in **octenilin® wound irrigation solution**
- Day 21:** Shrinkage of the damaged peristomal skin area to just 1 cm around the stoma
- No impairment of appliance adherence to the peristomal skin
- Significant increase in the patient's quality of life
- High satisfaction with the treatment course

Treatment time with octenidine

21 days



Day 1



Day 5



Day 18



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Case 44 | Peristomal skin complication

Patient

91-year-old female

Clinical presentation

Damaged skin around a colostomy

Medical history

- Rheumatoid arthritis, osteoporosis
- Colostomy for 15 years as a result of a rectal adenocarcinoma
- Flat two-piece ostomy system (base plate and detachable pouch)
- Stoma care routine: Washing the peristomal skin with mild soap including thoroughly drying

- Recurrent hypergranulation and bleeding around the stoma without signs of infection
- Occasional topical application of silver nitrate
- Upon admission:** Extensive and bleeding-prone hypergranulation in two quadrants around the stoma; extreme dissatisfaction of the patient with her quality of life

Wound care with octenidine

- Days 1, 5 and 10 (inpatient setting):** Cleansing and disinfection of the peristomal skin with **octenisept®**, followed by chemical cauterisation of the hypergranulation tissue using silver nitrate and subsequent application of the base plate

- Outpatient setting:** During each base plate change (every 3–4 days), cleansing and disinfection of the peristomal skin with **octenisept®**; regular care of the peristomal area
- Significant increase in the patient's quality of life
- High patient satisfaction with the treatment course

Treatment time with octenidine

28 days



Day 1



Day 7



Day 28



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Case 45 | Peristomal skin complication

Patient

34-year-old female

Clinical presentation

Damaged skin around a colostomy

Medical history

- Colostomy and an extensive abdominal wound for more than 3 years
- Present stoma was re-established three months before after a failed reversal attempt; initial stoma had been created following a colonic perforation during colonoscopy

- Once or twice daily change of stoma appliance
- Pain management with morphine, paracetamol, codeine, ibuprofen
- Previous treatments with Manuka honey, alcohol-free stoma paste, hydrocolloid dressings, sucralfate powder
- Significant mental health comorbidities
- Upon admission:** Hypergranulation, erythema, inflammation, excoriation, weeping, moisture-associated skin damage caused by leakage of stomal effluent, extending in a 2.5 cm radius around the stoma; severe pain

Wound care with octenidine

- Days 1–14:** During each pouch change, gently cleansing by dabbing a gauze soaked in **octenilin® wound irrigation solution** onto the peristomal skin for 5 minutes; after drying, application of appliance
- Day 7:** Peristomal skin complications already decreased by 80%, with a marked reduction in pain
- Significant increase in the patient's quality of life
- High patient satisfaction with the treatment course

Treatment time with octenidine

14 days



Day 1



Day 7



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Case 46 | Tattoo

Patient

30-year-old female

Clinical presentation

Large black-and-white portrait tattoo on the left upper arm

Procedure

- Cleansing and disinfection of the skin area with **octeniderm*** prior to tattooing
- Afterwards, washing with a pH-neutral soap and complete coverage of the tattoo with a Suprasorb* F film dressing for 5 days

Wound care with octenidine

From day 5: **octenisept*** protect & repair cream applied 2–4 times daily, depending on skin dryness

Treatment time with octenidine

38 days

Day 1



Day 7



Day 42



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Case 47 | Tattoo

Patient

42-year-old male

Clinical presentation

Coloured tattoo depicting a coronavirus motif on the left thigh

Procedure

- Cleansing and disinfection of the skin area with **octeniderm*** prior to tattooing
- Immediate post-tattoo coverage with cling film for about 5 hours
- Afterwards, washing with a pH-neutral soap

Wound care with octenidine

From day 1: **octenisept*** protect & repair cream, applied 2–4 times daily, depending on skin dryness

Treatment time with octenidine

28 days

Day 1



Day 14



Day 28



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Indications and labels depicted in this document are according to the Austrian registration of the corresponding products and may differ in other countries. Please consider respective SmPC/product information for further information.

octenisept® — Lösung zur Wund- und Schleimhautdesinfektion

Zusammensetzung: 100 g Lösung enthalten: 0,1 g Octenidindihydrochlorid, 2,0 g 2-Phenoxyethanol. **Anwendungsgebiete:** Zur wiederholten, zeitlich begrenzten antiseptischen Behandlung von Schleimhaut und Übergangsepithel vor operativen Eingriffen, – in der Mundhöhle z. B. vor Zahnextraktionen oder Kürettagen, – im Urogenitaltrakt z. B. vor Hysterektomien – und im Rektalbereich z. B. vor dem Veröden von Hämorrhoiden. Im Vulvovaginalbereich mittels Applikator-Sprühkopf bei unkomplizierten bakteriellen Infektionen und Infektionen durch Pilze. Zur zeitlich begrenzten Wund- und Nahtversorgung sowie zur zeitlich begrenzten antiseptischen Behandlung infizierter Wunden der Haut. octenisept® kann bei Erwachsenen und Kindern ohne Altersbegrenzung eingesetzt werden. Die Unbedenklichkeit und Sicherheit der Anwendung ist auch bei Frühgeborenen ab der 24. Schwangerschaftswoche nachgewiesen. **Gegenanzeigen:** Überempfindlichkeit gegen die Wirkstoffe oder einen der sonstigen Bestandteile. octenisept® sollte nicht zu Spülungen in der Bauchhöhle und der Harnblase und nicht am Trommelfell angewendet werden.

Vorsichtsmaßnahmen: Um möglichen Gewebeschädigungen vorzubeugen, darf das Präparat nicht unter Druck ins Gewebe eingebracht bzw. injiziert werden. Bei Wundkavitäten muss ein Abfluss jederzeit gewährleistet sein (z.B. Drainage, Lasche).

Hilfsstoffe: (3-Cocosfettsäure-amidopropyl)-dimethylazaniumylacetat, Natrium-D-gluconat, Glycerol 85%, Natriumchlorid, Natriumhydroxid, gereinigtes Wasser. **Abgabe:** rezeptfrei, apothekenpflichtig. **Wirkstoffgruppe:** Pharmakotherapeutische Gruppe: Antiseptika und Desinfektionsmittel, ATC-Code: D08AJ57; Octenidin, Kombinationen. **Zulassungsinhaber:** Schülke & Mayr Ges.m.b.H., Seidengasse 9, A-1070 Wien. **Stand der Information:** 07.2024. Weitere Angaben wie Dosierung und Art der Anwendung, Warnhinweise und Vorsichtsmaßnahmen für die Anwendung, Wechselwirkung mit anderen Arzneimitteln und sonstige Wechselwirkungen, Fertilität, Schwangerschaft und Stillzeit sowie Nebenwirkungen oder Gewöhnungseffekte entnehmen Sie bitte der veröffentlichten Fachinformation.

octeniderm® — Lösung zur Hautdesinfektion

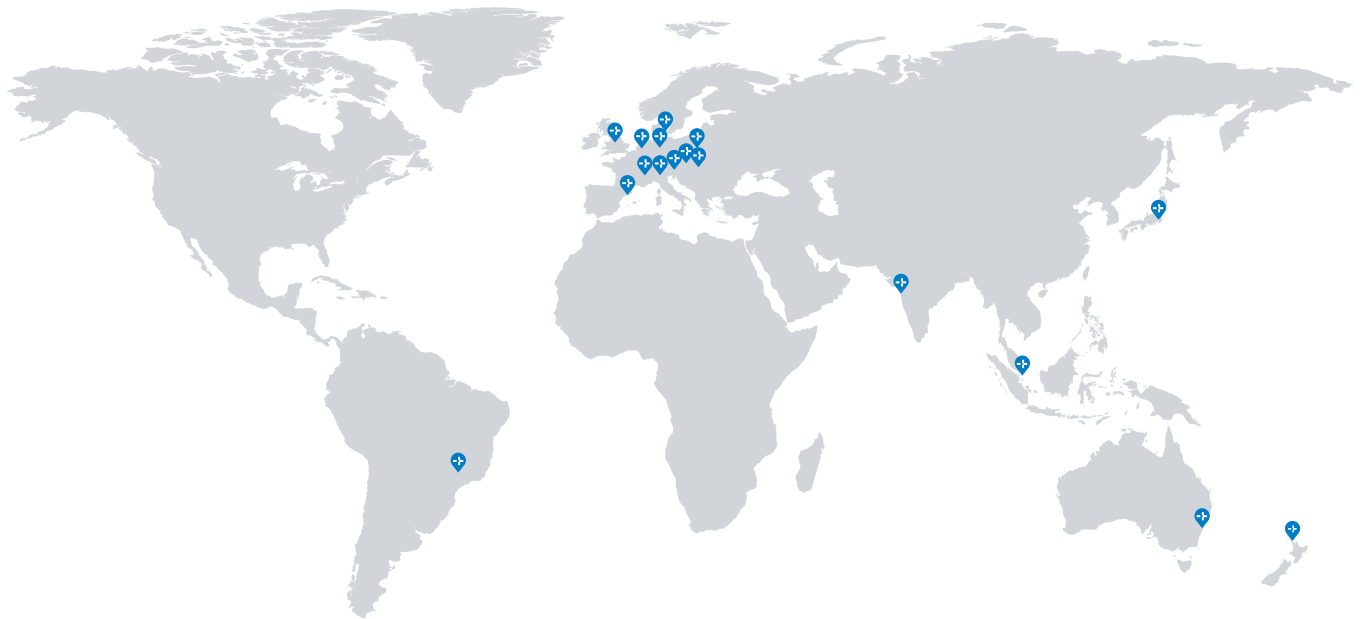
Zusammensetzung: 100 g Lösung enthalten: 30,0 g 1-Propanol, 45,0 g 2-Propanol, 0,1 g Octenidindihydrochlorid. **Anwendungsgebiete:** octeniderm® ist ein Antiseptikum zur Hautdesinfektion vor operativen Eingriffen, Katheterisierungen von Blutgefäßen, Blut- und Liquorentnahmen, Injektionen, Punktionen, Exzisionen, Kanülierungen, Biopsien sowie zur zeitlich begrenzten Nahtversorgung und zur zeitlich begrenzten Prävention katheterassoziierter Infektionen. octeniderm® weist eine remanente Wirkung von 48 h auf. **Gegenanzeigen:** Überempfindlichkeit gegen die Wirkstoffe oder einen der sonstigen Bestandteile. octeniderm® soll aufgrund des hohen Alkoholanteils nicht bei Frühgeborenen und Neugeborenen mit unreifer Haut angewendet werden. **Abgabe:** rezeptfrei, apothekenpflichtig. **Wirkstoffgruppe:** Pharmakotherapeutische Gruppe: Antiseptika und Desinfektionsmittel, ATC-Code: D08AJ57, Octenidin, Kombinationen. **Zulassungsinhaber:** Schülke & Mayr Ges.m.b.H., A-1070 Wien, Tel. (+43) 1/523 25 01. **Stand der Information:** 01.2023. Weitere Angaben wie Dosierung und Art der Anwendung, Warnhinweise und Vorsichtsmaßnahmen für die Anwendung, Wechselwirkung mit anderen Arzneimitteln und sonstige Wechselwirkungen, Fertilität, Schwangerschaft und Stillzeit sowie Nebenwirkungen entnehmen Sie bitte der veröffentlichten Fachinformation.



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