Guidelines for the Diagnosis and Management of Leg Ulcers in Bradford and Airedale

DATE DEVELOPED: MARCH. 2000
REVIEW DATE: MARCH. 2002

Recommendation statements graded as follows:

I Generally consistent finding in a majority of multiple acceptable studies

II Either based on a single acceptable study, or a weak or inconsistent finding in multiple acceptable studies

III Limited scientific evidence which does not meet all the criteria of acceptable studies of absence of directly applicable studies of good quality. This includes published or unpublished expert opinion

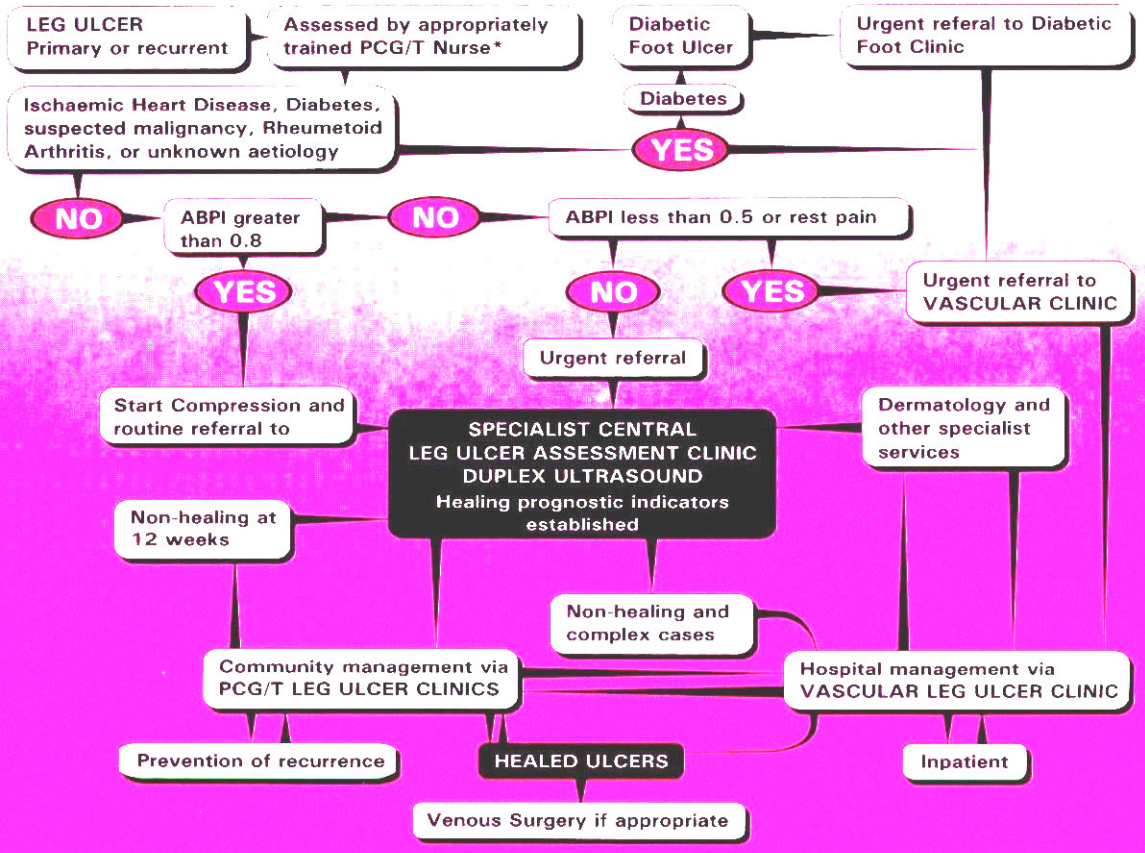
IIIb As agreed by PACE

ABPI = Ankle Brachial Pressure Index

DIAGNOSIS AND MANAGEMENT OF LEG ULCERS

A leg ulcer is defined as a loss of skin below the knee which takes more than 6 weeks to heal

Dale et al 1983



*Refer to 1998 RCN Guidelines

Guidelines have been developed by a multi-professional team from across Bradford and Airedale

DIAGNOSIS AND MANAGEMENT OF LEG ULCERS

Assessment

IIIa Assessment and clinical investigation should be undertaken by a health care professional trained in leg ulcer management.

III Examine both legs and record the presence/absence of the following:

III venous disease: usually shallow (usually on gaiter area of leg); oedema; eczema; ankle flare; lipodermatoscierosis; varicose veins; hyperpigmentation; atrophic blanche.

IIIb arterial disease: 'punched out appearance; base of wound poorly perfused and pale; cold legs/feet; shiny. taut skin: dependent rubour; pale or blue feet; gangrenous toes.

III mixed venous/arterial: features of venous ulcer in combination with signs of arterial impairment.

I All patients presenting with an ulcer should be screened for arterial disease by Doppler measurement of ABPI.

I Patients with an ABPI of less than 0.8 will have arterial disease.

III The size of the ulcer will be recorded at presentation and every 12 weeks by either, scaled photography or mapping.

III Specialist medical referral may be appropriate for:

- Treatment of underlying medical problems
- Ulcers of non-venous aetiology
- Suspected malignancy
- Diagnostic uncertainty
- Reduced APBI
- Increased APBI
- Rapid deterioration of ulcers
- Newly diagnosed diabetes
- Signs of contact dermatitis
- Cellulitis
- Healed Ulcers with a view to venous surgery
- Ulcers which have received adequate treatment and have not improved after 12 weeks
- Recurring ulceration
- Ischaemic foot
- Infected foot
- Pain management

III Routine bacterial swabbing is unnecessary unless there is evidence of clinical infection such as: inflammation/redness/evidence of cellulitis, increased pain, purulent exudate, rapid deterioration of the ulcer, pyrexia.

Management

I Graduated multi-layer high compression systems (including short-stretch regimens), with adequate padding, capable of sustaining compression for at least a week, should be first line of treatment for uncomplicated venous ulcers (ABPI > 0.8).

II The compression should be applied by a trained practitioner.

I Simple non adherent dressings are recommended in the treatment of venous ulcers, as no specific dressing has been shown to improve heating rates.

I Hydrocolloid or foam dressings may be of value in painful ulcers.

I Ulcerated legs should be washed normally in tap water and carefully dried.

II Health professionals should regularly monitor whether patients experience ie pain associated with venous leg ulcers and formulate an individual management plan, which may consists of compression therapy, exercise, leg elevation and analgesia to meet the needs of the patient.

I Antibiotics should be reserved for evidence of cellulitis or active infection before grafting.

II Topical antibiotics are frequent sensitisers and should be avoided.

I Systemic therapy in the treatment of leg ulcers is not recommended.

III Formal reassessment should be carried out 12 weeks after the start of treatment and thereafter at 12 week intervals.

II Use of compression stocking reduces venous ulcer recurrence rate.

I Correctly fitted graduated hosiery should be prescribed for all patients who have successfully healed their venous ulcer. (study results only available for 5 years)

READ CODES

75u4 Leg Ulcer	50Be Mixed Arteriovenous Leg Ulcer
50Bb Leg Ulcer Nos	50Bi Neuropathic Leg Ulcer
50Bd Venous Ulcer of Leg	50Bf Ischaemic Leg Ulcer