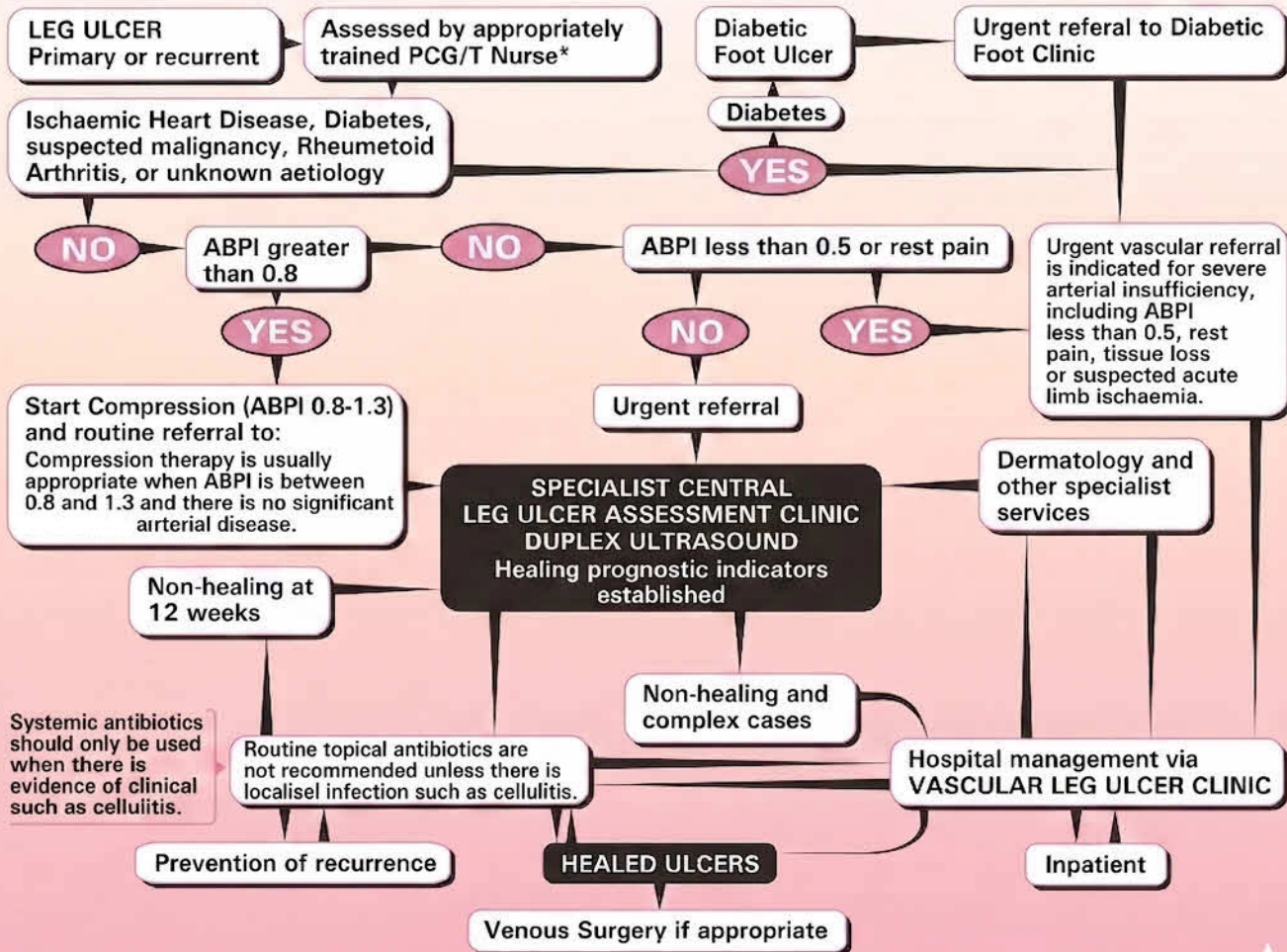


# DIAGNOSIS AND MANAGEMENT OF LEG ULCERS



A leg ulcer is generally defined as a break in the skin below the knee that has not healed within 2 weeks or is not healing as expected.


Dale et al 1983



\*Refer to 1998 RCN Guidelines

# DIAGNOSIS AND MANAGEMENT OF LEG ULCERS

## Assessment

- III A leg ulcer is generally defined as a break in the skin below the knee that is not healed within 2 weeks or is not healing as expected. 
- 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; lipodermatosclerosis; varicose veins; hyperpigmentation; atrophic blanche.
- III arterial disease: 'punched out appearance'; base of wound poorly perfused and pale; cold legs/feet; shiny, tight skin; dependent rubour; pale or blue feet; gangrenous toes.
- III mixed venous/arterial: features of venous ulcer in combination with signs of arterial impairment.

All patients 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.

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III Specialist medical referral may be appropriate for:

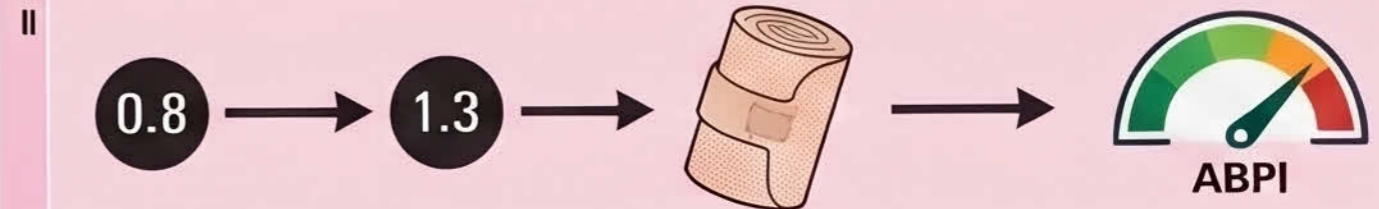
- Treatment of underlying medical problems
- Ulcers of non-venous aetiology
- Reduced ABPI or evidence of arterial disease
- Suspected malignancy
- Suspected malignancy
- Diagnostic uncertainty
- Rapid deterioration of ulcers
- Newly diagnosed diabetes
- Signs of contact dermatitis
- Cellulitis
- Healed Ulcers with a view to venous surgery
- Non-healing ulcers after 12 weeks
- Recurring ulceration
- Infected foot
- Pain management
- Newly diagnosed diabetes

Urgent vascular referral is indicated for severe arterial insufficiency, including ABPI less than 0.5, rest pain, tissue loss or suspected acute limb ischaemia. [cite: 1]

- III Note on Bacterial Swabbing: Routine bacterial swabbing is unnecessary unless evidence of clinical signs such as cellulitis. [cite: 1]

## Management

I Graduated multi-layer high compression systems. ABPI is between 0.8 and 1.3 and there is no significant arterial disease.



II Simple low-adherent dressings are recommended; no single dressing type has been shown to improve healing rates independently. [cite: 1]



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

II Topical antibiotics are frequent sensitizers and should be avoided.

5 Routine topical antibiotics are not recommended unless there is localised clinical infection. [cite: 1]



II Systemic 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)

6 Systemic antibiotics should only be used when there is evidence of clinical infection such as cellulitis. [cite: 1]



## READ CODES

- |                          |                                    |
|--------------------------|------------------------------------|
| 75u4 Leg Ulcer           | 50Ba Mixed Arteriovenous Leg Ulcer |
| 50Bb Leg Ulcer Nos       | 5091 Neuropathic Leg Ulcer         |
| 50Bd Venous Ulcer of Leg | 309f Ischaemic Leg Ulcer           |