Information for staff

NHS
Berkshire Healthcare
NHS Foundation Trust

Managing Leg Ulcers

Occurring between the ankle and the knee, leg ulcers may take more than two weeks to show any signs of healing.

Common leg ulcers include:

- **Venous** which develop due to high pressure in the veins of the leg with skin damage present
- **Arterial** caused by poor blood circulation in the arteries
- **Mixed** because of problems with both the arteries and veins (venous and arterial)
- **Neuropathic** due to poor neurological function of the peripheral nervous system
- **Trauma** caused by injury to the leg, such as skin tears.

Many factors impact the healing process of leg ulcers, things to consider are blood supply, oedema present in the leg, past medical history, smoking, medication, and choice of dressings.

There are also rare but important causes of skin ulceration, which include:

- **Pyoderma gangrenosum** causing large, painful sore to develop most commonly on the legs
- **Vasculitis** identified as inflammation of the blood vessels, possibly triggered by infection and/or medication.
- **Necrobiosis lipoidica** a less common inflammatory condition, presenting in shiny, red/brown, or yellowish patches on the skin- commonly on the shins
- **Infection** which may cause swelling of the leg, pain, increased exudate, and malodour
- **Tumours** also known as fungating cancers grow under the skin and breaks through the skins surface in the shape of a fungus or cauliflower.

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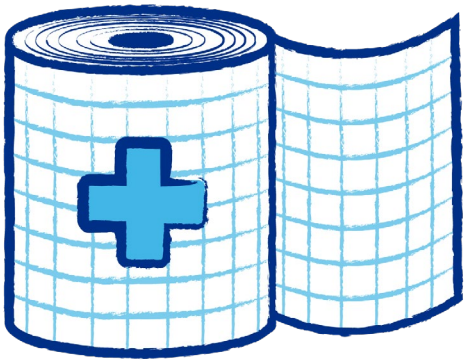
When managing leg ulcers, **a full history** needs to be completed to identify the type of ulcer and the cause. Always remember to consider why they have an ulcer and treat underlying causes, if appropriate, refer on to other services to multi-disciplinary working, such as the Vascular services, or lymphoedema services.



Assessment of appropriate **analgesia** is paramount for the patient due to pain, consider regular administration if pain is continuous or before dressing changes as patients commonly find dressing changes uncomfortable and/or painful.

Make sure the **ulcers, leg(s) and feet are washed** at least weekly, or more frequently if dressings are being changed more than once a week.

Infection is a cause of ulceration, however a swab from ulcer surfaces offer limited help as bacterial colonisation of chronic ulcers is commonly present on the wound bed. A clinician can consider topical steroids such as Trimovate to help dry up overly exudative ulcers following assessment.

Compression therapy is a helpful aid for wound healing non-venous leg ulcers e.g., pyoderma gangrenosum, vasculitis. Carcinomas are contra indicated in compression, seek advice from a dermatology viewpoint.

Always **consider rarer causes** of leg ulceration if they fail to improve despite appropriate wound management, addressing risk factors and rapid progression. Wounds are a symptom of an underlying condition.

It is paramount that full and holistic assessment occurs, and where all care has been implemented with no successful outcome, a wound biopsy should be considered.

If you have any questions, contact the Tissue Viability Nurses
tissueviability@berkshire.nhs.uk

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