Patient has wound on leg between knee & ankle

NHS Oxford Health NHS Foundation Trust

ASSESS FOR RED FLAGS:

- Cellulitis of leg or foot (unilateral not 'red legs')
- Suspected sepsis
- Acute or chronic limb threatening ischaemia
- Suspected acute DVT (until anticoagulated & pain manageable)
- Suspected skin cancer

If oedema present, refer to Heart Failure and Compression pathway and Chronic Oedema pathway prior to progressing with this pathway.

If no Red Flags present, start compression with 20mmHg immediately: with either hosiery delivering 20mmHg, Ko-Flex (18-25cm), or KTwo reduced (ankle>25cm)

REFERRAL

- Wound below malleolus/ ankle refer to podiatry who will be lead clinicians
- Diabetic with wound to foot URGENT same day referral to diabetic podiatry at OCDEM
- Acute or chronic ischaemia urgent referral to Vascular & also Tissue Viability for wound advice
- Suspected skin cancer ask GP to refer to dermatology for Biopsy

- Complete a full holistic assessment including an ABPI within 2 weeks
- Patient medical & lifestyle history
- Lower limb assessment and doppler including pulse sounds
- Wound assessment
- Map & photograph wound

Select appropriate dressing using TIMES and wound formulary:

T - Tissue Management
I - Inflammation/infection & biofilm management
M - Moisture balance
E - Epithelial (edge) advancement
S - Surrounding skin care

! DO NOT USE ADHESIVE DRESSINGS ON LEGS EXCEPT FOR KLINIDERM SILICONE BORDER
! DO NOT DEBRIDE A SUSPECTED ARTERIAL WOUND WITHOUT TV ADVICE

SKIN CARE

- Use emollient as soap substitute
- Bowl wash to remove exudate & hyperkeratosis
- Apply a leave on emollient in downward strokes
- Refer to wound formulary for emollient advice
- Follow varicose eczema pathway if necessary

High numbers of bacteria in a wound delays healing.

Are there signs of local or spreading or infection?

LOCAL INFECTION: Delayed wound healing, friable granulation, slough or necrosis might be present, increased purulent exudate +/- odour, new/increased pain - MANAGEMENT = 2 weeks antimicrobial dressings - refer to AMBL2 tool

SPREADING/SYSTEMIC INFECTION: Wound deteriorating, spreading erythema, systemically unwell - MANAGEMENT = 2 weeks antimicrobial dressings, wound swab & oral antibiotics - refer to AMBL2 tool

ABPI < 0.6 ARTERIAL DISEASE

No compression Urgent referral to TissueViability & vascular

ABPI 0.6 – 0.8 MIXED DISEASE

Reduced compression 20mmHg Refer to vascular

ABPI 0.8 – 1.3 VENOUS DISEASE

Full compression at least 40mmHg Refer to vascular for venous duplex scans & possible sclerotherapy

ABPI > 1.3 CONSIDER CALCIFICATION

Refer to TVN for advice

If oedema also present > 3 months refer also to chronic oedema pathway

Reassess wound every 4-6 weeks
If less than 40% reduction in 6 weeks, and no explanation why, refer to TVN

After 12 weeks of treatment
If wound not healed, refer to TVN

Once leg ulceration has healed -
apply maintenance compression

COMPRESSION OPTIONS

FULL COMPRESSION

40mmHg

1st line Hosiery Kit – If low exudate and leg good anatomical shape.

2nd line – Compression bandages. Actico if mobile - apply 2nd layer from ankle up if ankle >25cm after K-soft; KTwo if less mobile/fixed ankle - select correct size for ankle circumference

Wrap garments are not intended for use with leg ulceration

REDUCED COMPRESSION

20mmHg

1st line – Hosiery delivering 20mmHg

2nd line – Compression bandages **-**
Ko-Flex (ankle 18-25cm)
KTwo Reduced (ankle >25cm)

CHRONIC OEDEMA

1st line – Double layer Actico with 8 & 10cm for below knee

2nd line – Coban 2 for very misshapen legs and thigh high bandaging. Only available through referral to Tissue Viability

Refer to Chronic Oedema Pathway

MAINTENANCE COMPRESSION

1st line – Hosiery. No oedema = Activa; Oedema = Actilymph or MTM. Refer to hosiery formulary
2nd line – Wrap garments. No oedema = Farrowwrap 4000; Oedema = JUZO ACS Light