

LIVE

TUESDAY 30TH AUGUST, 7.30PM

Part 2 - Leg Ulcer Series: Interim Care: Progressing towards self-care

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LIVE Q&A

*SEND IN YOUR QUESTIONS BY COMMENTING
ON THE VIDEO*

LEARNING OBJECTIVES



To understand recommendations and best practice implementation for treatment of venous leg ulcers (VLUs) that are not yet suitable for self-care compression solutions



Have the knowledge to be able to implement practical solutions to progress these patients' wounds to a point where self-care may become appropriate

WELCOME & RECAP

THE BURDEN OF LEG ULCERS



£3.1b

Annual estimated healthcare cost associated with leg ulcers (Guest et al, 2020).

One million patients

(2% of the UK adult population) affected with a leg ulcer (Guest et al, 2020).

50%

of community nursing time is taken up on wound care (NWCSP, 2020).

Up to 69%

of leg ulcers recur once healed annually (Harding et al, 2015).

Change is a MUST to reduce the burden of wounds for the NHS and sufferers.

NATIONAL WOUND CARE STRATEGY PROGRAMME (NWCSP)



Recommendations
for Clinical Care

The unwarranted variation in UK wound care services offers major opportunities to improve healing rates and thus reduce patient suffering, spend on inappropriate and ineffective treatments and the amount of clinical time spent on wound care (NWCSP, 2020).

Evidence-based recommendations for lower limb care address three areas to support best practice implementation (NWCSP, 2020):

- Immediate and necessary care
- Diagnosis and treatment
- Ongoing maintenance.

RECAP

Part 1 in this leg ulcer series focused on:

- **IMMEDIATE AND NECESSARY CARE**
- The importance of and how to recognise red flags
- Immediate use of <20mmHg compression — do not delay
- Timelines for assessment and referral — do not delay
- End-to-end management: prevention is key, ongoing support is required post healing.

Catch up on **Leg Ulcers: Immediate care to prevention of recurrence:**
<https://www.facebook.com/events/1082630069127600/>

BEST PRACTICE TREATMENT FOR VLU

TREATMENT OF A VENOUS LEG ULCER

NWCSP (2020) recommendations for managing wounds on the leg:

Diagnosis and treatment

1 Assess and identify contributing causes for non-healing

2. Diagnose cause of non-healing and formulate treatment plan

Leg wounds with an adequate arterial supply and no aetiology other than venous insufficiency

- Refer for venous surgical/endovenous interventions.
- Strong compression therapy.

Leg wounds with signs of arterial disease

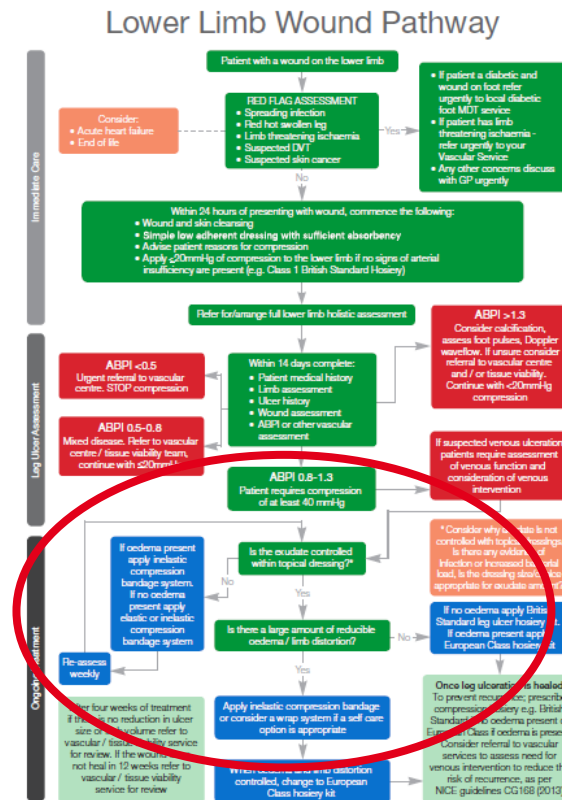
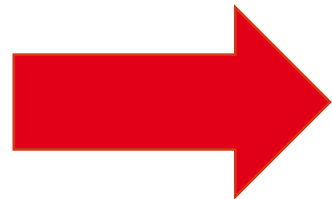
- Refer for vascular surgical/endovenous interventions and advice on compression.
- Pending vascular opinion, if no symptoms of arterial insufficiency, continue with mild graduated compression.

Leg wounds of other or uncertain aetiology

- Refer for dermatology opinion (or other specialist depending on symptoms and service arrangements).
- Pending specialist opinion if no symptoms of arterial insufficiency, continue with mild graduated compression.

Lymphoedema

- Refer for expert diagnosis and advice about lymphoedema.



(Atkin and Tickle, 2016)

Watch out for the Leg Ulcer Series.
Part 3: Embracing supported self-care
Tuesday October 11, 2022

FULL THERAPEUTIC COMPRESSION IS REQUIRED TO HEAL A VLU

Once assessment confirms there is adequate arterial supply, **STRONG** compression (at least 40mmHg) and an appropriate wound care regimen is required (Wounds UK, 2016).

This is vital.

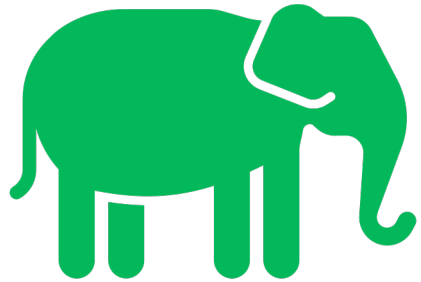
MYTH

Reduced compression is therapeutic for VLUs.

TRUTH

While some compression is better than none, clinicians should always aim to use full compression systems when the vascular assessment deems it appropriate to do so, in order to prevent delays in healing through use of sub-therapeutic compression.

THE ELEPHANT IN THE ROOM!



Based on data (Guest et al, 2020), an estimated 85% of those with a LU suitable for compression have an ulcer that is venous in origin, yet 26% of all compression bandages sold are reduced systems (GPrX).

Positively promote the use of FULL compression to your patients — education, appropriate language.

Address pain — effective compression reduces inflammation and therefore can relieve pain. Use analgesia if necessary.

Remove the fear for clinicians of doing harm — allowing chronicity does more harm. Choose a system you are confident cannot be overstretched.

SELF-CARE COMPRESSION SOLUTIONS ARE RECOMMENDED FIRST LINE

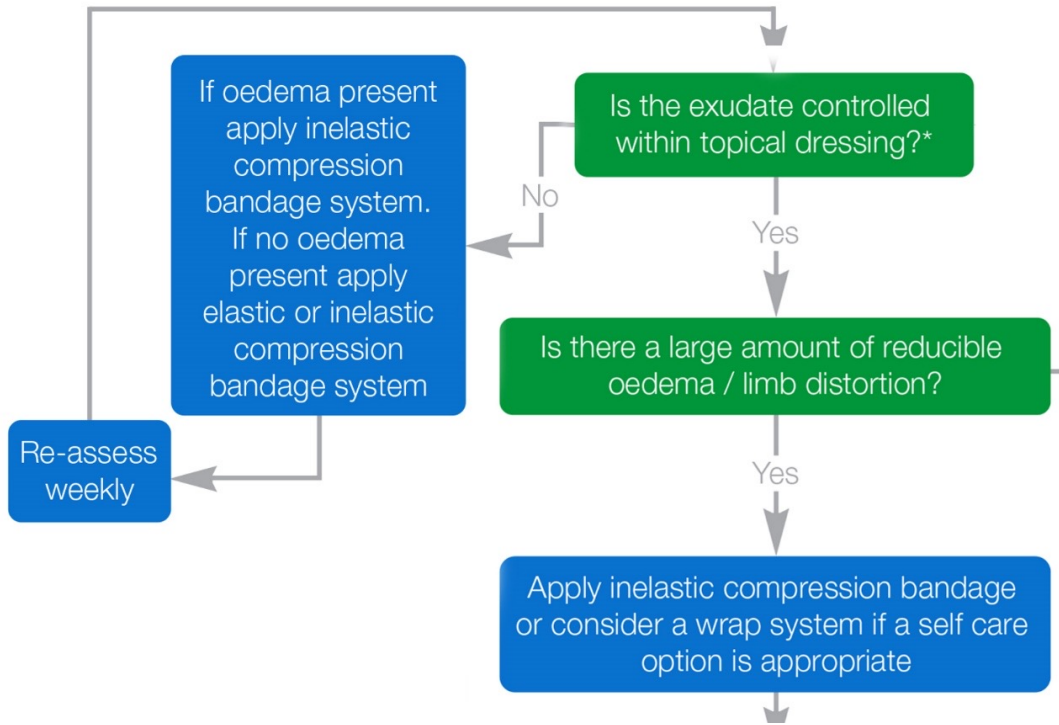
- Exudate controlled
- Minimal oedema and/or limb distortion.

* May be applied by the patient or a carer.

More on this in part three of the Leg Ulcer Series: Embracing supported self-care.



WHEN SELF-CARE SOLUTIONS ARE NOT YET SUITABLE



High exudate volume and/or large amount of reducible oedema/limb distortion.

SETTING THE SCENE ON EXUDATE AND OEDEMA

WHAT IS EXUDATE?

A fluid that, when the skin is intact, would usually bathe the cells within the dermis, providing nutrients (Davies, 2012).

When there is an injury to the skin, exudate is exacerbated as part of the inflammatory response, and in moderation is an essential component of the healing process (Dowsett, 2011; World Union of Wound Healing Societies [WUWHS], 2019).



ROLE OF EXUDATE

- **Exudate plays an essential role in the normal healing process by maintaining a moist wound bed**
- This is achieved by:
 - Supplying the essential nutrients to allow cells to metabolise
 - Helping tissue repairing cells to migrate where needed
 - Allow dead or damaged tissue to separate from good tissue (autolysis)
- In normal wound healing, the volume of exudate will decrease as healing occurs (Flanagan, 2013; Kerr, 2014).

Sometimes
misconceived
as **BAD**

WHY LEG ULCERS ARE OFTEN HIGHLY EXUDING

- Venous insufficiency
- Lymphatic insufficiency
- Limb dependency
- Inactive calf muscle pump
- Engorgement of capillary bed
- Size/surface area of wound
- Ineffective levels of compression
- Infection or biofilm.



Sub-therapeutic 'light' compression and/or inadequate dressing



Gravity – long periods of time with legs in dependent position

EXUDATE AND CHRONIC LEG ULCERS

Exudate can be detrimental, because it:

- Encourages bacterial growth
- Causes higher levels of inflammatory factors
- Interferes with the normal healing process
- Can be corrosive to surrounding skin
- Has a significant impact on patient quality of life (Wounds UK, 2013).



Delayed healing

DRESSING SELECTION – ABSORB THE EXCESS

A dressing used to manage exudate should:

- Optimise wound bed moisture level
- Absorb and retain exudate
- Protect the surrounding skin
- Conform well to the limb
- Be cost-effective
- Not adhere to the wound/surrounding skin
- Prevent strikethrough
- Be safe and effective to use under compression (WUWHS, 2019).



WHAT IS CHRONIC OEDEMA?

The term chronic oedema acts as an umbrella description of abnormal swelling of tissues which lasts for more than three months, regardless of whether it is lymphatic or venous in origin (Humphreys et al, 2017).

It is a symptom rather than a diagnosis.



OEDEMA CASCADE

- Initially soft and pitting
- Chronic skin changes
- Fibrosis in skin
- Eczema
- Hyperkeratosis
- Lipodermatosclerosis
- Risk of skin breakdown/
ulceration.



EFFECT OF UNCONTROLLED EXUDATE AND OEDEMA



Impact to
healing



Impact to
the **patient**



Impact to
the **clinician**



Impact to the
wider **NHS**

ESCALATING IMPROVEMENT

DEBRIDEMENT

- Removes debris from wounds
- Removes physical barriers to healing
- Reduces bioburden
- Removes nutrients that bacteria feed on
- Creates an acute response.

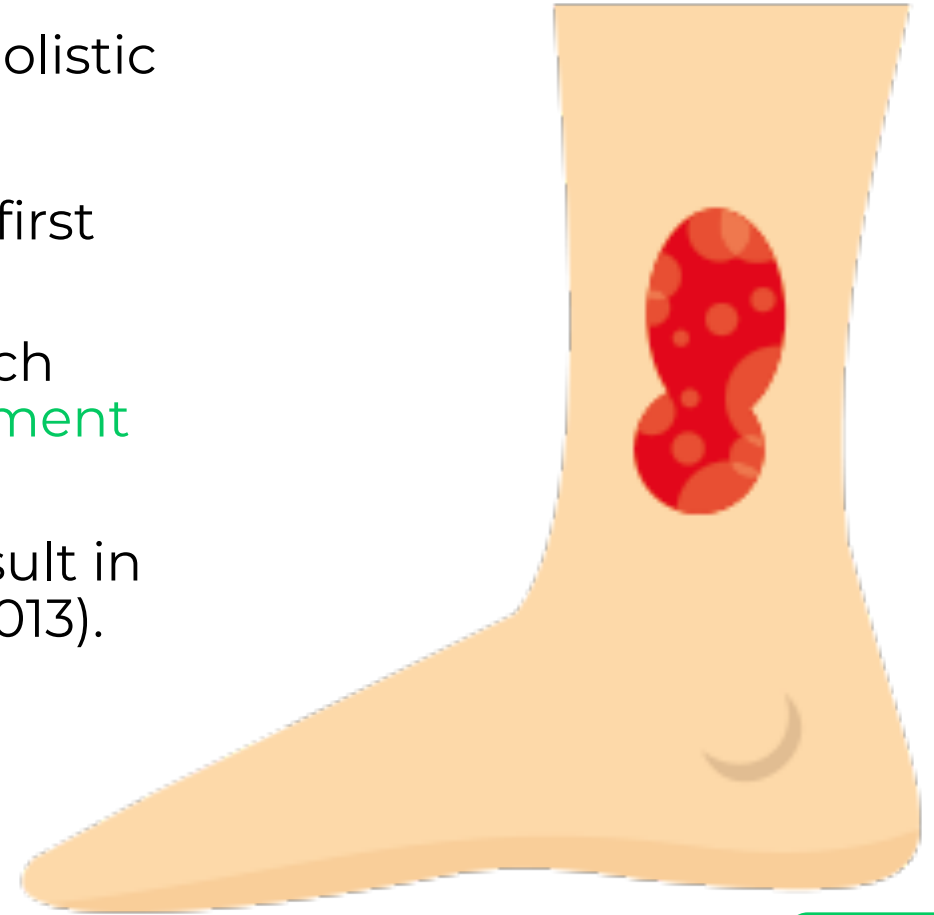
Therefore, reduces exudate volume and promotes cascade through healing process (Wounds UK, 2013).



SELECTING A DEBRIDEMENT METHOD

The Best Practice Statement (Wounds UK, 2016) Holistic Management of Venous Leg Ulcers states:

- **Mechanical debridement** should be used in the first instance for thorough cleansing
- A high percentage of VLUs will have biofilm which **needs to be disrupted with mechanical debridement** before antimicrobial control
- Wounds treated with **frequent debridement**, result in significantly **shorter healing time** (Wilcox et al, 2013).



DEBRIDEMENT

- Clean it like you mean it!
- Use appropriate cleansing solutions
- The goal is to eliminate all unwanted materials and 'wake-up' the wound
- Debridement that does not achieve pinpoint bleeding may not physically remove the biofilm
- Autolytic debridement alone is insufficient
- Don't forget emollients post cleansing/debridement.



Before

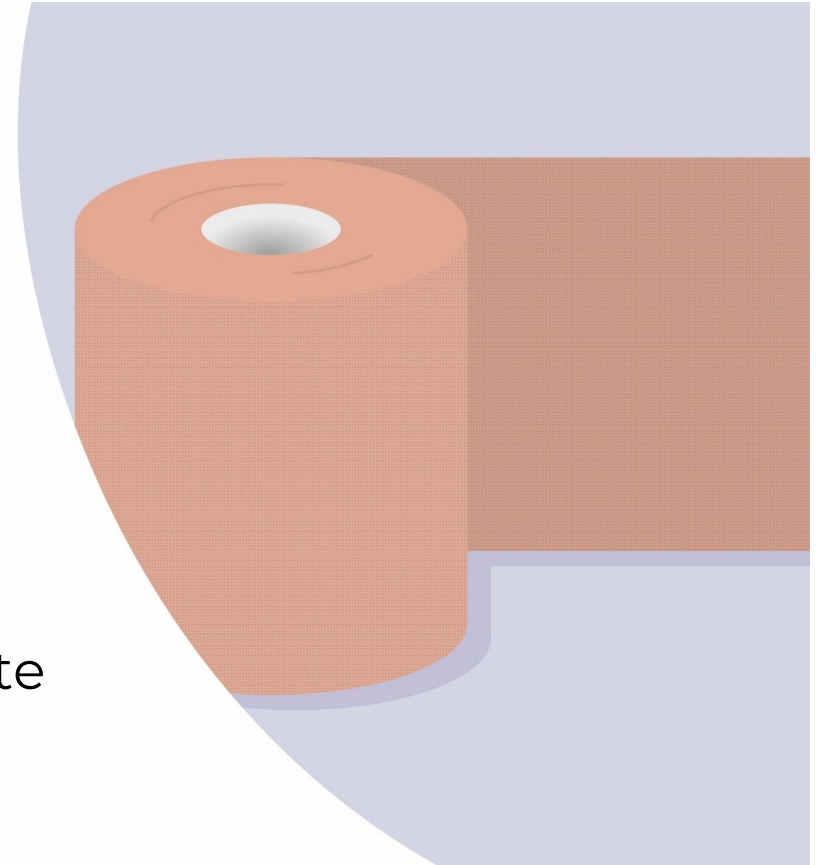


After

REDUCE EXUDATE/OEDEMA AND PROGRESS HEALING

COMPRESSION IS FUNDAMENTAL:

- It improves venous return
- Opposes leakage of fluid from capillaries into tissues, improving lymphatic return
- Treats the underlying cause
- Reduces limb congestion
- Reduces inflammatory effects
- Allows the wound to move out of an inflammatory state (Wounds International, 2013; Harding et al, 2015).



COMPRESSION OPTIONS

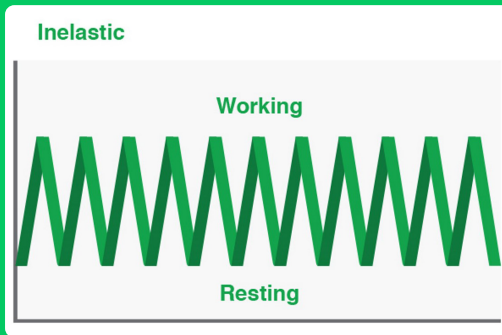
Appropriate systems for the clinical scenario:

Scenario	Hosiery Kits	Wraps	Bandages
Normal leg shape	✓	✓	✓
Low-to-moderate exudate	✓	✓	✓
Self-caring	✓	✓	✗
Distortion due to oedema	✗	✓	✓
High exudate	✗	✗	✓
Deep skin folds	✗	✗	✓



EFFECT OF ELASTICITY ON THE WAY COMPRESSION IS DELIVERED

Inelastic Bandages

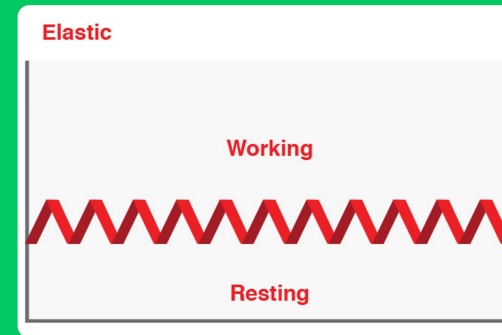


Provide stiff support and prevent outward expansion

Working and resting pressures provide a massage effect, reduction in venous hypertension and stimulates lymphatic uptake

Recommended for limbs **with or without oedema**

Elastic Bandages



Allow a degree of limb expansion

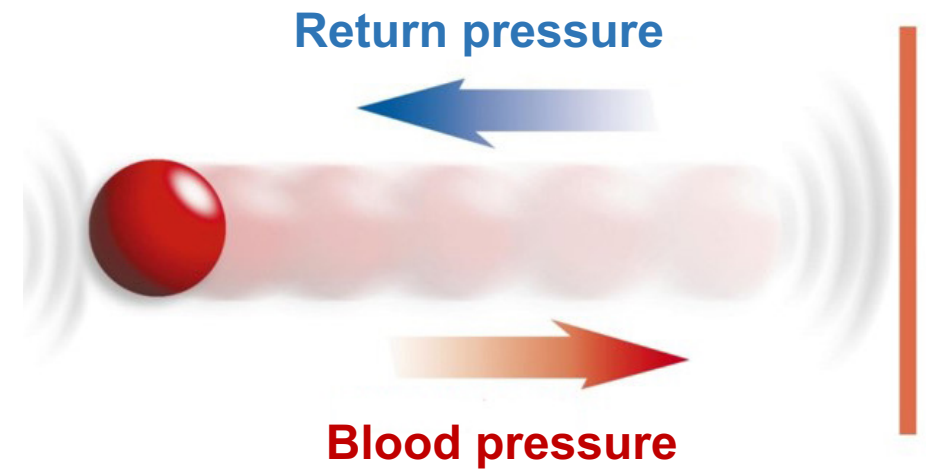
Exert a more constant pressure with little change in pressure on movement

Recommended for non-oedematous legs

WORKING AND RESTING PRESSURE

‘Working pressure’ — on movement, the calf muscle contracts, expands and rebounds against the bandage creating intermittent high pressure peaks which pushes the blood upwards.

‘Resting pressure’ — when the limb is resting, the pressure exerted by the bandage is lower.



INELASTIC BANDAGES AND IMMOBILE PATIENTS

MYTH

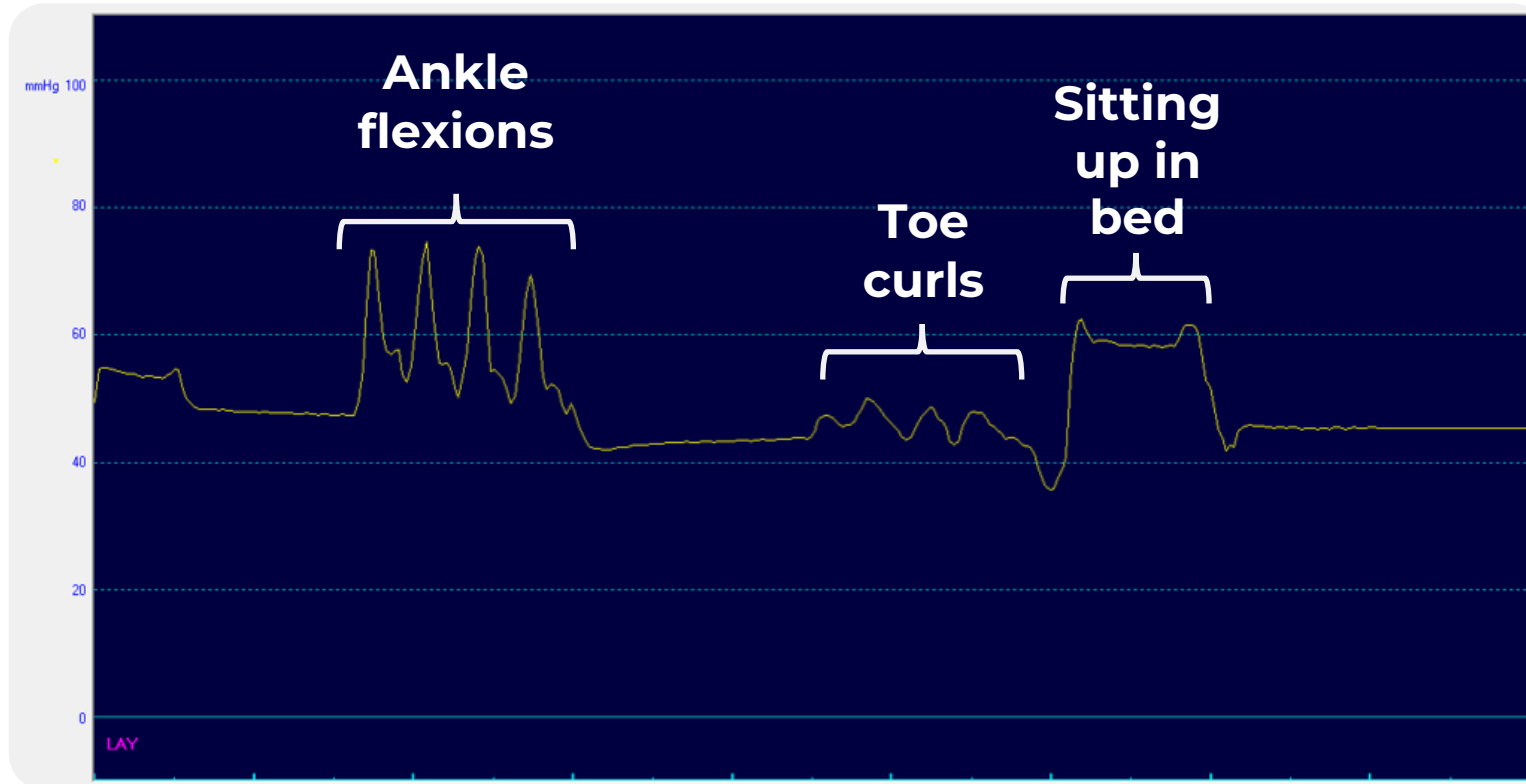
Inelastic bandages
are not suitable for
immobile patients.

TRUTH

Inelastic bandages can
be used on both mobile
and immobile patients,
as fluctuations in
pressure can be achieved
even with small or
passive movements to
facilitate venous return.

Inelastic bandages provide pressure peaks even during small ankle flexions, making them suitable for immobile as well as mobile patients (Charles et al, 2009; Wounds UK, 2016).

INELASTIC BANDAGES: EFFECTIVE FOR IMMOBILE PATIENTS



PicoPress measurement recorded while applied to a healthy volunteer.

Fluctuations in pressure can be achieved even with small or passive movements (Franks et al, 2004).



ACTICO

- **Therapeutic working and resting pressures:**
 - Mimics the operation of healthy valves
 - Effective treatment of venous leg ulcers and oedema (Franks et al, 2004)
 - Greater comfort at rest (Clements, 2007)
- **Adaptable:** for a wide range of lower limb conditions
- **Applied at full stretch:** reduces fear of over-compression for peace of mind for consistently safe, accurate and easy application (Knowles et al, 2013).



MOVING THROUGH THE PATHWAY

Evidence based
leg ulcer management

Prevention and
Early Intervention



Prevention of Recurrence

SETTING PATIENTS' EXPECTATIONS



It should be an expectation that the wound progresses



Inform the patient that the first sign of improvement is reduction of limb and exudate volume — wound reduction comes second



Once exudate volume subsides and oedema reduces, choice of compression should be re-evaluated and self-care garments considered



This pathway should be outlined from the outset, so there is expectation, understanding and acceptance of the need to change.

CLUB SQUEEZE IN



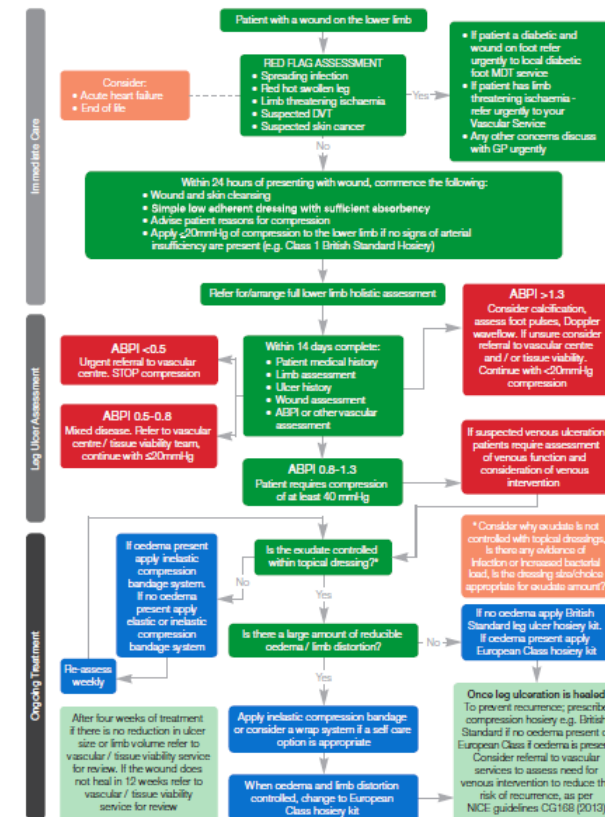
Club **SQUEEZE IN**

- 'Squeeze In' aims to empower people to manage their leg health to support improved outcomes and release nursing time back to care.
- To support your patients with leg ulcers from first aid to prevention of recurrence sign up to squeeze in today: www.squeezein.life

IN SUMMARY

- Follow an evidenced-based pathway
- Consider self-care first, but if exudate and oedema prevent this:
 - Debride and remove the reason
 - Absorb the excess fluid — protect the skin
 - Compress to progress — reduce congestion and inflammation
- Full therapeutic compression is required
- Engage with the patient to ensure progression through the pathway.

Lower Limb Wound Pathway



(Atkin and Tickle, 2016)

KEY TAKE AWAY QUESTIONS



- Are you healing patients with venous leg ulcers or simply managing the symptoms?
- Are all your patients who are suitable in full strong compression?
- Do your patients truly understand the reasons for compression – and that their compression journey is going to be a lifelong one?

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