

CORE TUTORIALS IN DERMATOLOGY FOR PRIMARY CARE

PDP SELF-TEST QUESTIONNAIRE

LEG ULCERS

METEOR CRATER,
ARIZONA, USA



UPDATED PDP SELF-TEST QUESTIONNAIRE
AUGUST 2023

‘Ulcer’ Full thickness loss of epidermis and some dermis, which will heal with scarring

CORE TUTORIALS IN DERMATOLOGY FOR PRIMARY CARE

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PDP SELF-TEST QUESTIONNAIRE

INTRODUCTION

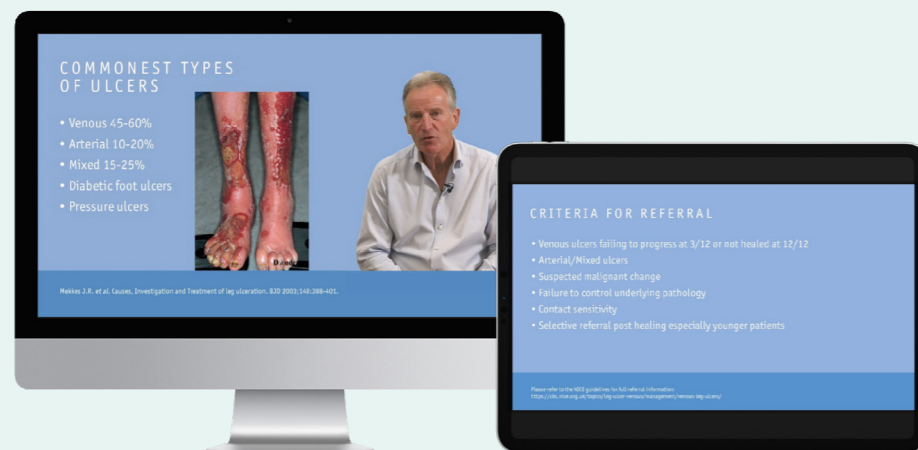
This 'self-test questionnaire' has been written by Dr Brian Malcolm, based on the updated (2023) Chapter 5 "Leg Ulcers" of the Core Tutorials in Dermatology for Primary Care. This revised Chapter can be ordered from Dermal at the address below. Alternatively, the Chapter is available to download from the Dermal website - www.dermal.co.uk within the Healthcare Professionals Core Tutorials in Dermatology section.

DERMAL RESOURCES

For 60 years Dermal has focused on researching and developing innovative dermatological treatments. In addition, Dermal has developed an extensive range of educational resources to assist healthcare professionals and patients. These can be found on the Dermal website - www.dermal.co.uk. Our Healthcare Professionals section of the website contains a variety of information and educational materials, such as information about our range of products, resources for healthcare professionals and patients, the Core Tutorials in Dermatology series and links to useful external websites.

The Core Tutorials in Dermatology series are also available as engaging webinars, to complement the written Chapters. These can also be found on the Dermal website.

The webinar on Leg Ulcers provides a useful overview of the topic including assessment, treatment options, complications and referral criteria.



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QUESTIONS

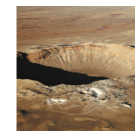
1. What is the annual prevalence of leg ulcers in the UK?

2. What percentage of leg ulcers are wholly arterial?

3. Below what Doppler reading should compression bandaging be routinely avoided?

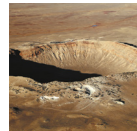
4. What healing rates can be achieved for venous ulcers with 4 layer bandaging for 12 weeks?

5. What type of wounds are alginate dressings most suitable for?



QUESTIONS

6. How high are the recurrence rates for venous ulceration in the 12 months after healing?
7. What percentage of patients with leg ulceration have at least one relevant co-morbidity?
8. Give some examples of commonly prescribed drugs that can adversely influence wound healing?
9. What percentage of venous ulcers occur in the 'gaiter' area?
10. Are routine swabs for microbiology useful in the assessment of leg ulcers?



REFLECTIVE LEARNING

11. What did I find useful about the learning module on 'Leg Ulcers'?
12. Having reflected on this module, how might my practice change in managing Leg Ulcers?

QUESTION 1. Answer: 2%

Ref page 1 "The annual prevalence in adults of venous ulceration is 2%, an increase of 71% between 2012 and 2018."²⁷

QUESTION 2. Answer: 10%

Ref page 2 "It is important to define what we mean by a venous leg ulcer. Definitions vary from an area of epidermal discontinuity lasting in excess of 2-6 weeks, occurring as a result of venous hypertension and calf muscle insufficiency. Such ulcers will comprise the majority estimated at between 70-80% of all leg ulcers, 10% will be of an arterial aetiology and 10-20% of a mixed aetiology. Recent research demonstrates that a diagnosis was not recorded in 25% of cases!"

QUESTION 3. Answer: 0.8

Ref page 5 "A reading of 1 or above indicates normal arterial flow; 0.8 would be the lowest level that full compression could be considered safe. Below this reading there is likely to be significant arterial disease and a vascular opinion should be considered. Modified compression can be used in experienced hands. Spuriously high and falsely reassuring Doppler indices can be obtained in poorly compressible, calcified vessels most commonly evidenced in diabetics. The paradox of leg ulcer treatment is that the best possible treatment for venous ulcers is the worst possible treatment for arterial ulcers, and the road to effective ulcer healing is littered along the way with avoidable medicolegal catastrophes! Worriingly however, only 15% of venous leg ulcers have a Doppler assessment recorded and of the 85% with no recording, 29% were treated with compression!"²⁸

QUESTION 4. Answer: 70%

Ref page 6 "The gold standard was the Charling X 4 layer bandage with studies reporting 70%+ healing rates in 12 weeks.⁷ The present median duration of a venous leg ulcer in the community is nine months. A study from Cardiff then demonstrated using a 3 layer measured tubitrip system achieved 66% healing in the same period.⁸ Further outcome data from this study demonstrated 51% of venous ulcers were relatively easy to heal, but 33% particularly difficult to heal with responses correlating inversely to both the chronicity of the ulcer and its size at the onset of treatment. The application of multi-layer bandaging systems requires a significant degree of nursing expertise."

QUESTION 5. Answer: Moderate or heavily exudative wounds

Ref page 8 "(4). **Alginates** e.g. Kaltostat: Derived from seaweed, very absorbent, hydrating and haemostatic. These can be used in moderate or heavily exuding wounds."

QUESTION 6. Answer: Up to 70%

Ref page 9 "The most pessimistic data regards present recurrence rates which can be as high as 70% at one year, rising almost to 100% at five years if the deep veins are abnormal. Well fitted compression hosiery post healing and the advent of "healed ulcer" clinics or "leg clubs" will hopefully continue to impact on these depressing statistics as well as a greater understanding of skin barrier function by nursing staff and carers particularly in relation to its age related compromise. The application of open toe class II compression hosiery changed every three months in the Cardiff study reduced recurrence to 11%!⁸ A well informed patient who has been involved at all stages in their treatment is more likely to comply with post healing regimes."

QUESTION 7. Answer: 95%

Ref page 2 "One fundamental principle has to be established before we proceed. A leg ulcer is not a diagnosis but a manifestation of an underlying disease process; 95% of patients have at least one co-morbidity with a mean of 4.1 comorbid conditions.¹ This is why we doctors must continue to be involved. It is in this sphere that the skills and training to look at the greater picture through our 'wide-angled lenses' and not just focus on the leg ulcer, but the 'patient WITH the leg ulcer.'"

QUESTION 8. Answer: Non-steroidal anti-inflammatory, steroids, immunosuppressants, beta blockers and nicorandil

Ref page 3 "All assessment tools should address the following:"

Drug history – especially:

- Non-steroidal anti-inflammatory
- Corticosteroids + other immunosuppressants
- Beta blockers
- Nicorandil

QUESTION 9. Answer: 88%

Ref page 4 "(1). **Site** – 88% of venous ulcers occur in the so called 'gaiter' area. Most commonly on the medial aspect; however, extensive venous ulcers can extend to adjacent areas of the leg. If an ulcer lies exclusively outside of the gaiter area, then you must question whether it is of venous origin. Arterial ulcers commonly occur on the dorsum or plantar aspect of the foot or on the toes."

QUESTION 10. Answer: No – only for defined clinical indications

Ref page 5 "Full blood count, U+Es, TFTs and urinalysis would suffice as a basic minimum with other tests as indicated from the medical history and examination. There is no place for routine swabs. These should only be taken when infection or presence of a significant biofilm is clinically evident, either by excessive exudate and malodour, sudden deterioration or acute onset of pain or cellulitis."

ANSWERS (PLEASE TURN UPSIDE DOWN)

