Introduction
This case study presents the challenges faced by a general nurse specialising in leg ulcer care when treating a patient with intravenous (IV) drug abuse resulting in ulceration. It highlights a different perspective when discussing non compliance, treatment aims and acknowledgement of realistic outcomes.

Maria is a 29 year old female with a 17 year history of substance misuse and is an IV drug user. She presented to the Warwick leg ulcer service with extensive left lower leg ulceration, present for approx 4 years (Picture 1) approx. 30 x 15cms, with no undermining, wound base 100% thick green slough with an overwhelming odour and a visual analogue scale of pain recorded at 9 (10 = unbearable pain). Exudate level was high, with no evidence of spreading cellulitis.

Past medical history included left deep vein thrombosis and femoral vein occlusion, also from IV drug use. Maria also admitted continued use of illicit drugs by injection and inhalation. Previous treatments had been initiated by district nurses, practice nurses and community leg ulcer clinics but, due to missed appointments and non attendance, these were unable to be sustained.

A Warwickshire leg ulcer care pathway (based on RCN guidelines 2006) and assessment was completed, including measurement of the ankle brachial pressure index (greater than 0.9 bilaterally) indicating a good arterial supply and extensive venous disease. A wound swab for culture and sensitivity identified faecal and skin flora.

Method
Before admission could be agreed, an inpatient methadone programme was commenced with the help of Maria’s key drug worker and psychiatrist.

This admission was a rare but vital opportunity to address urgent wound care issues requiring a multidisciplinary approach, including dermatology/vascular/plastics/dietician/ pain and physiotherapy team reviews. Blood tests revealed iron and vitamin deficiencies with anaemia (Hb 8mmol).

Dressing selection needed to manage high levels of exudate, to extensively debride but also enable a pain free application and ease of removal. In addition, the dressings needed to be easily available and cost effective. The leg ulcer nurse selected an ionic sheet hydrogel dressing (ActiFormCool®) (Picture 2) to cover the ulcer, with a short stretch bandage system (Actico®) (Picture 3). Maria was advised to rest on the bed with leg elevation, and was provided with high protein diet and iron supplements.

Results
Maria remained an inpatient for 2 weeks before absconding from the hospital for over 6 hours and thus, self discharging. During this period of time the wound base had improved significantly (Picture 4) with a wound base of pink healthy granulation tissue, controlled exudate and good pain relief, with no evidence of clinical infection.

Conclusion
Leg ulcer case studies often report on non concordance/compliance - often relating to elderly patients, evidence of bandage tampering and requests for increased nurse visits. The importance of understanding non concordance and the challenges of leg ulcer patients has been discussed by Moffatt (2004) and Roden (2009). This case study in contrast, identifies a young girl whose wound dressings and bandages were often left for 2 weeks. These were often saturated with exudate and a high odour, with many missed, haphazard appointments. The described admission period demonstrated that, with the correct dressing selection and holistic management, the ulcer showed excellent progress and healing in a short period of time. However, the author acknowledges individual patient physical and psychological challenges which do not always result in a positive wound healing outcome.

Maria returns to the leg ulcer clinic sporadically and the wound care challenges continue.

References