CARE OF A PATIENT WITH A LARGE VENOUS LEG ULCER

Anna Coulbourn is Tissue Viability Nurse and Cathie Bree-Actan is Tissue Viability Consultant, Wound Healing Centre, Eastbourne

A 56-year-old woman who was obese, presented with bilateral leg ulcers. The patient was using two sticks to mobilise but was still active. She owned a florist shop and spent many hours standing making bouquets but was able to rest at home with her legs elevated.

She had suffered with bilateral leg ulcers for many years and her wounds were particularly difficult to treat because she was unable to tolerate compression therapy and many dressings caused her extreme pain. Her wound was subsequently being managed rather than treated.

Many different types of dressings and bandaging regimens had been previously used to help her wound to heal but few had been tolerated and often had to be removed within a short period of time. Maggot therapy had had an initial success at a cost of £300 for one application, but they were only in situ for four hours as the pain became intolerable. The patient was currently managed using a hydrofiber dressing with silver which was changed twice-weekly. A system of bandaging with a layer of gauze tubular unbleached bandage and a wadding layer followed by reduced compression was also being applied, which the patient was able to tolerate.

On initial assessment, her wound was yellow, sloughy, extremely malodorous and producing large volumes of exudate (Figure 1). This had resulted in maceration around the wound edge. The peri-wound area was over-hydrated but intact (Figure 2), suggesting colonisation of bacteria although there were no signs of clinical infection.

Doppler assessment showed the ankle brachial pressure index (ABPI) to be 0.9 in the right leg. The ankle measured over 25cm and the calf was large due to obesity. The patient was unable to tolerate full compression which had been attempted on many occasions but the pain had been too great. The aim was to reduce the pain through cleaning and healing the wound, so that compression would be tolerated.

Management of exudate was extremely important as the patient often stood for long periods of time and this increased the fluid loss, making her uncomfortable and embarrassed. Thus, to control the exudate levels in the wound, Aquacel® (Convatec, Ickenham) was applied as a primary dressing and was covered using Filvasorb® (Activa Healthcare, Burton-upon-Trent), a highly absorbent dressing. After one week the hydrofiber dressing was changed to Suprasorb X +PHMB for a further week to control the colonisation of bacteria. The Filvasorb was then continued as the primary dressing and very successfully locked the exudate in its centre (Figure 4). Reduced compression was continued and the stockinette was placed over the Filvasorb.

On removal of the dressing after the first 24 hours, the Filvasorb appeared to have drawn the exudate away from the wound surface leaving it moist but not wet. Although there was strike-through when the hydrofiber and stockinette was placed under the Filvasorb (Figure 3), it can be clearly seen in Figure 4 that Filvasorb successfully retained the fluid in the centre of the dressing and there was no strike-through to the bandages.

Filvasorb and Suprasorb X +PHMB successfully controlled the exudate and were both acceptable to the patient who was free of maceration. At no time did the nurses experience strike-through in this lady's dressings while Filvasorb was used as a primary or secondary dressing.

The patient's wound is unlikely to heal, nevertheless, the symptoms can be reduced by the use of appropriate dressings and this can increase the quality of life for the patient with a difficult and complex wound.