

Venous Leg Ulcer – Management protocols in MGMMCH, JSR and RIMS, Ranchi

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Abstract: Introduction: venous ulcer is most common type of chronic leg ulcer. In this study we have tried to manage the venous ulcer by various methods in RIMS, Ranchi, and MGMMCH Jamshedpur.

Material and methods: This is a prospective study done over a period of 1 years. All Patients of venous ulcer were firstly managed conservatively and followed-up. The patients which does not respond to conservative treatment was managed by different surgical and endovessel methods.

Result: 92.9% patients were male and 7.1% were female. Mean ulcer size at presentation was 37.5 cm. 85.7% ulcers healed completely on conservative treatment at 3 month follow up, another 9.5% healed at 5 months followup and

in 4.7% cases surgical treatment was required.

Conclusion: in this two institutes good healing rate is achieved in treatment of venous ulcer with conservative management.

Keywords: leg ulcer, varicose vein, chronic venous insufficiency, compression stocking, sclerotherapy, ligation and stripping.

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I. Introduction

There are three main types of leg ulcers - venous, arterial, and neuropathic. Venous ulcers are most common (75%) of all chronic leg ulcers.

Venous ulcers develop due to chronic venous insufficiency (CVI).

Causes of chronic venous insufficiency are:

A) Primary varicose veins¹

B) Secondary varicose veins which develop most commonly after deep vein thrombosis.

C) Failure of the valves and

D) Predisposing factors like old age, obesity, and prolonged dependent posture.

Chronic venous insufficiency leads to inflammatory reactions in interstitial tissue ultimately resulting in development of venous ulcer. For confirmation of diagnosis Duplex scan with color flow is the investigation of choice. Plethysmography and Ascending & descending venography may occasionally be required.

Treatment Options For Venous Ulcer Are-

A) Leg elevation above the level of heart reduces edema, improves venous drainage and microcirculation.

B) Elastic Compression stocking therapy¹ - reduces edema and pain, improves venous circulation and enhances ulcer healing. Lifelong maintenance of compression therapy after ulcer healing reduces the rate of recurrence.

C) Medications⁵- Pentoxifylline has additive beneficial effect to compression. Aspirin, Intravenously administered iloprost and prostaglandin E1 analogue can also be used.

D) Mechanical Negative pressure wound therapy⁷, hyperbaric oxygen therapy

E) Debridement if required and different types of dressing materials like hydrocolloids, foams, hydrogels, pastes and simple non-adherent dressings.

F) Surgical management is indicated for ulcers that are large, of prolonged duration or not responsive to conservative measures. Split-thickness skin grafts, local flaps and microvascular flaps, any of the above can be used.

II. Material And Method

This is a prospective longitudinal study of patients with venous leg ulcers treated in the department of general surgery, RIMS, Ranchi and MGMMCH, Jamshedpur; from December 2017 to January 2018.

Patients of leg ulcer coming to surgery OPD were examined and those having venous ulcer (diagnosed by clinical examination and Doppler study) were included in the study. Venous leg ulcers^{1,8,13} were defined as any ulcer located below the knee with one or more of the following manifestations: edema, hyperpigmentation (stasis dermatitis), eczema, lipodermatosclerosis, and varicose veins.

The exclusion criteria were leg ulcers of any other etiology and venous ulcers associated with peripheral artery disease. Size of the ulcer in each case was measured by tracing its borders onto clear paper and measuring it. Treatment offered-

1> If the venous ulcer was infected and was covered with necrotic/infected granulation tissue, it was first treated by regular debridement and dressing.

2> In patients having venous ulcer covered with healthy red granulation tissue treatment advised consisted combination of - lower limb elevation + regular and continuous use of graduated pressure stockings + regular dressing of the wound with amorphous hydrogel with colloidal silver ointment + tab. Pentoxifylline 400 mg TDS.

Ulcer size measurements were taken weekly for three months (some cases needed longer follow-up). Most patients showed good response with above treatment protocol. In those patients who didn't show signs of improvement even after 3 months with above treatment protocol, surgical treatment was considered for further management. Surgeries performed in such patients in our institution were-surgical treatment of primary venous pathology (flush ligation¹⁵ of great saphenous vein at saphenofemoral junction and/or foam sclerotherapy) + partial thickness skin grafting/local advancement & rotation flaps to cover the ulcer.

III. Result

A total of 84 cases of venous ulcer were included in this study. Out of that 78(92.9%) were male and 6(7.1%) were female. Mean age of patient population was 49 years with SD=7.25 years (range-35 to 61 years). In all cases ulcer was located in medial aspect of lower leg near medial malleolus. Mean ulcer size at presentation was 37.57cm² with SD =26.20cm² (range 7 to 110cm²).

With the conservative treatment provided in this study, most ulcers showed good healing response. At three months follow up- in 36(85.7%) cases ulcers were completely healed, in 4(9.5%) patients ulcers were reduced to <25% of its initial size and in only 4(4.7%) cases no significant improvement was seen. In these 4 cases with no improvement after 3 months of conservative treatment; surgical treatment was done.

Surgery done was- flush ligation of great saphenous vein at saphenofemoral junction +stripping and foam sclerotherapy for smaller varicosities.

This was followed by split thickness skin grafting at ulcer site done 1 week after stripping. These 4 cases were completely cured at 4th months of treatment.

IV. Discussion

Venous ulceration is the outcome of chronic venous insufficiency in the leg.¹ In this study we have tried to summarize our experience about treating venous ulcer in RIMS, Ranchi; and MGM medical college Jamshedpur. This study was done over a period of 1 year.

According to this study males are affected with venous ulcer more commonly than females and this difference is statistically significant. All the venous ulcers were located in medial lower leg. Treatment offered to such patients in our institutes is a modified version of Bisgaard's regimen^{9,11}. At three months follow-up 85.7% cases were completely cured while 9.5% cases needed same treatment for 2 more months. In only 4.7% cases surgical treatment was required. Good response

with conservative management in treatment of venous ulcer is also seen in study done by William A. Marston et al.³⁰ Surgery performed in a particular patient depends on many factors and hence can vary from patient to patient.

V. Conclusion

Venous ulcers are the most common of all leg ulcers¹. Diagnosis is possible in most cases on clinical examination. Duplex scan with color flow is the investigation of choice to confirm the diagnosis.

In most cases conservative management with leg elevation, compression therapy, regular dressing and oral pentoxifylline is sufficient to cure the ulcer. Choice of dressing material is guided by local availability, cost-effectiveness and personal preference. Ulcers not healing on conservative management need surgery. Surgical therapy can vary from patient to patient depending upon the primary pathology. Aim of the surgery is to treat the primary disease and to cover the ulcer with skin graft/tissue flaps. Treatment standardization needs further study with larger study population and much longer follow-up

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