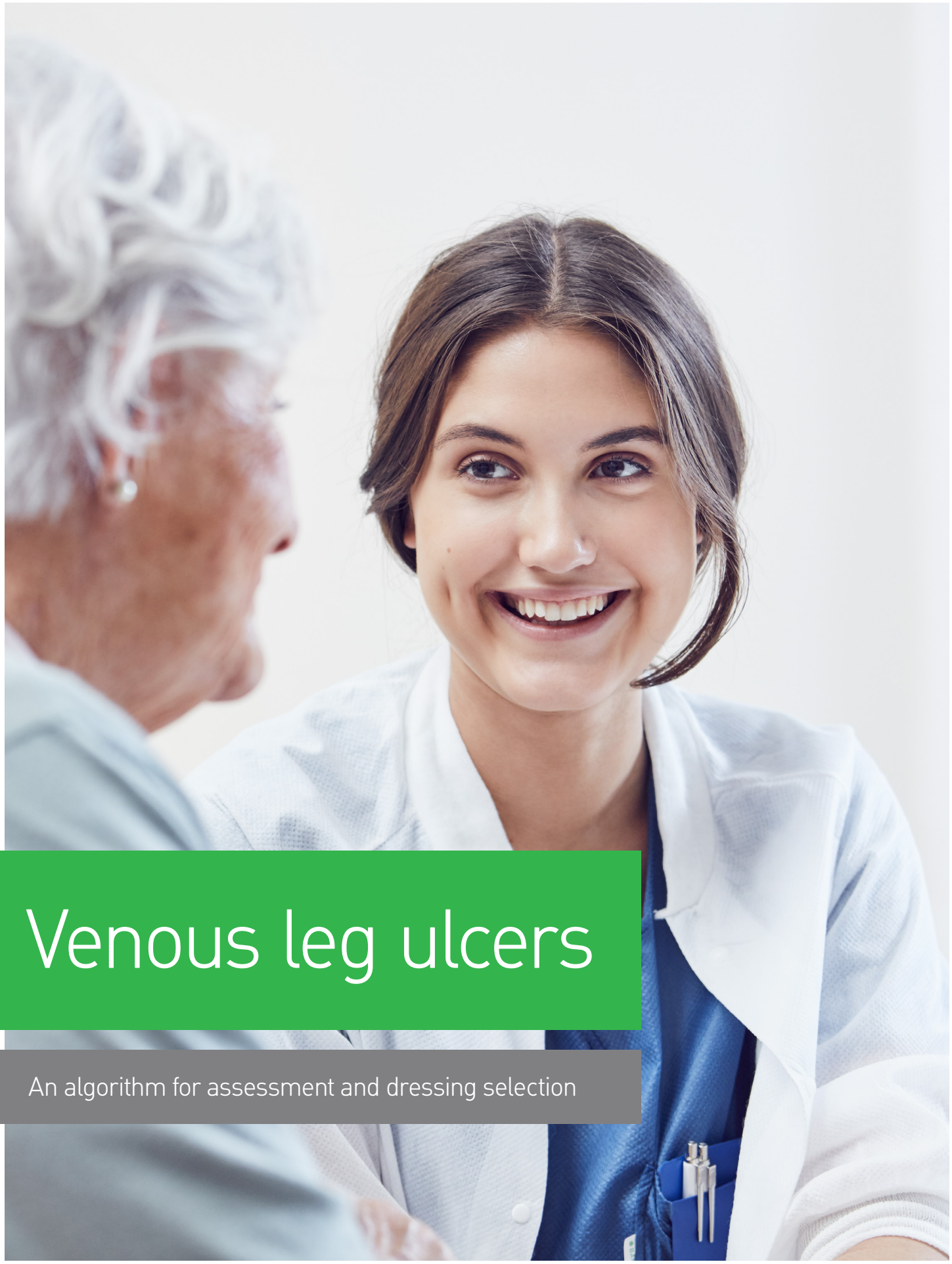


Venous leg ulcers

An algorithm for assessment and dressing selection

Mölnlycke®

Holistic assessment and manageme

Assessment of patients and lower limb

1 Medical history

- Physical, physiological and psychosocial health

2 Lower limb assessment

Signs of venous disease e.g.:

- Oedema
- Eczema
- Lipodermatosclerosis
- Altered shape – inverted 'champagne bottle'
- Varicose veins
- Ankle flare (distended veins in foot arch or ankle region)
- Haemosiderin pigmentation
- Atrophie blanche
- Other skin changes
- Evidence of healed ulcers

3 Vascular status and oxygenation levels

ABPI assessment with a Doppler. Referral to vascular specialist when ABPI: <0,8 or >1.4 or absolute systolic ankle pressure <60mmHg. When ABPI ≤0.5 urgent referral to vascular surgeon. A patient with an ulcer should be referred to vascular centre for consideration of venous interventions.

- Toe-brachial index (TBI) when ABPI: <0,8 or >1.4
- Consider oxygen assessment e.g. with transcutaneous oximetry ($TcPO_2$)

4 Wound and periwound

Infection:
Local signs of infection can be: increased exudate, non-healing, malodour, friable or discoloured granulation tissue, redness, pain, heat and swelling.

Wound bed, status/colour:
- Yellow slough
- Red granulation tissue, pink epithelialisation

Exudate
- Amount (none, low, moderate, high)
- Consistency/colour

- **Wound location**
- **Wound size (area/depth)**
- **Wound edge** (raised edge, undermining)
- **Surrounding skin** (maceration/excoriation, erythema, oedema)
- **Pain** (location, frequency, cause, type, intensity and duration)
- **Odour** (presence and nature)

5 Classification

Classification of Chronic venous insufficiency (CVI) with CEAP clinical classification. And Classification of the VLU as Simple or Complex.

Goals of treatment, education and concordance with the patient

Management of VLU[3,4]

A VLU has a negative impact on all aspects of the patients daily living and need to be considered in the treatment plan. VLU may cause depression, anxiety and social isolation, but also leaking exudate, pain, odour, restricted mobility and sleep disturbance may be particularly challenging and distressing for these patients.

- A Multidisciplinary team (MDT) can be a resource for planning and treat a patient with VLU, for example
- Recommend the best compression therapy for the individual
- Nutritional advice
- Infection control and treatment
- Full vascular assessment and treatment
- Assessment and treatment of different skin problems

Remember:[2-4]

- Assess and manage pain (local and systemic) before dressing changes.
- Be aware of mixed aetiology that includes venous disease. For example if other factors are present, e.g arterial disease, diabetes or rheumatoid arthritis (vasculitic ulcer).
- Wound biopsy may be indicated in patients who have delayed healing and a wound suspected of being malignant.
- Education and training of the patient, caregiver and family is essential in enhancing concordance.
- Reassess if wound area reduction is less than 20–30% after 4–6 weeks of optimal compression treatment.

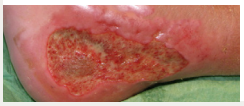
nt of patients with venous leg ulcers

Mölnlycke dressing selection guide

Infection

Requirement for antimicrobial	**No** requirement for antimicrobial

Wound bed

Red or Yellow	Red or Yellow
	

Appropriate debridement in combination with cleansing with Granudacyn®

Topical oxygen therapy with Granulox® If area reduction ≤40% after 4 weeks standard therapy[1]

Exudate level

	Mepilex® Ag	Mepilex® Border Lite
	Mepilex® Ag	Mepilex® XT
	Mepilex® Border Ag For yellow wounds Exufiber® Ag+ Mepilex® Border Flex	Mepilex® Border Flex For yellow wounds Exufiber® Mepilex® Border Flex
	Mepilex® Transfer Ag + Mextra® Superabsorbent	Mepilex® Transfer + Mextra® Superabsorbent

Use an appropriate moisturiser

ABPI assessment and compression therapy

Use an appropriate compression therapy (CT)[2], when needed use Tubifast® as an inner layer.

Doppler ABPI	0.51–0.79 Moderate PAD	0.8–0.90 Mild PAD	0.91–1.4 Borderline PAD between 0.91–0.99. Normal 1-1.4
CT in mmHg	15–30 mmHg*	15–40 mmHg*	15–50 mmHg

* Use modified CT with caution. Absolute systolic ankle pressure should be >60mmHg[2]

- Optimal wound management with provision of local treatment need to be supported with appropriate management of systemic disease, compression therapy and debridement. Remember that surgical debridement is contraindicated in some circomstences, for example if ischemia is present or pyoderma gangrenosum[5]
- Monitor at each dressing change and reassess regularly. Be sure that the dressing is compatible with the compression therapy
- If you need to cut the dressing, consider using non-bordered products
- The choice of dressings must be based on local protocols and clinical judgement

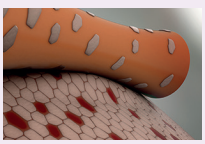
Proven choice for a better outcome

Safetac® is the original less-pain contact layer with silicone adhesion. We designed it to mould softly to skin without sticking to the moist wound[6] – so you can remove it easily without damaging the skin[7]. That means less pain for your patients[8].

Safetac also protects new tissue and intact skin – so wounds remain undisturbed to support faster natural healing[9-12]. And it seals the wound margins to protect skin from damaging leaks and maceration[13,14]. This combination of less pain[8] and less skin damage[7,10-13,15] – to support faster healing[9-12] – can also reduce the cost of treatment[10,11,15].

You can trust Mölnlycke® dressings with Safetac, for better patient and economic outcomes.

Safetac® TECHNOLOGY



Skin stripping occurs with traditional adhesive[7]

No skin stripping occurs with Safetac technology[7]

Dressing information

Mepilex® Border Lite

- Light foam dressing with soft silicone wound contact layer
- For non to low-exuding wounds; designed to maintain a moist wound environment
- Thin, soft, and highly conformable
- Can easily be cut to size
- Minimises pain and damage at dressing change[8]

Mepilex® XT

- Foam dressing with soft silicone wound contact layer
- For low to moderately exuding wounds; designed to maintain a moist wound environment
- Soft and conformable foam dressing
- Can easily be cut to size
- Mepilex XT can handle both low and high viscosity fluid[16]
- Minimise skin damage and pain at dressing changes[17]

Mepilex® Border Flex

- All-in-one bordered foam dressing with flex cuts and soft silicone wound contact layer
- For moderately to highly exuding wounds; designed to maintain a moist wound environment
- The Flex Technology allows Mepilex® Border Flex to move in every direction, reducing skin stress, increasing comfort and keeping it in place.[18-20]
- The 5-layer dressing absorbs and trap exudate containing bacteria and keep the exudate away from the wound bed, even under compression therapy (*in vitro*)[21]
- Minimise skin damage and pain at dressing changes[8]

Mepilex® Ag

- Antimicrobial foam dressing with soft silicone wound contact layer.
- For low to moderately exuding wounds, designed to maintain a moist wound environment
- Soft and conformable foam dressing
- Can easily be cut to size
- Mepilex Ag kills wound-related pathogens within 30 minutes; and carries on doing so for up to 7 days (*in vitro* studies)[22]
- Minimise skin damage and pain at dressing changes[8]

Mepilex® Border Ag

- Antimicrobial all-in-one bordered foam dressing
- For moderately to highly exuding wounds; designed to maintain a moist wound environment
- Combines excellent exudate management properties with antimicrobial action[23,24]
- Minimise skin damage and pain at dressing changes[8]

Exufiber®

- Gelling fibre dressing with silver (Exufiber Ag+) and without (Exufiber)
- For moderately to highly exuding wounds
- Transforms into a gel that provide moist wound environment[25-29] and softly conforms to the wound bed[25,27,28]
- The Hydrolock® Technology absorbs and locks in exudate, blood and bacteria[25,26,30]

Exufiber® Ag+

- The high structural integrity enables one-piece dressing removal[25-29, 31-34]
- The Silver in Exufiber Ag+ kills a broad range of pathogens (*in vitro*) and reduce biofilm, the antimicrobial effect is kept for up to seven days (*in vivo*)[35-37]
- Can easily be cut and used in cavities

Mepilex® Transfer

- Exudate transfer dressings with silver (Mepilex Transfer Ag) and wothout (Mepilex Transfer)
- Effectively transfer exudate to a secondary layer
- Very thin and conformable foam for difficult-to-dress locations
- Can easily be cut to size
- Mepilex Transfer Ag inactivates a broad range of microorganisms (*in vitro* studies)[38]

Mepilex® Transfer Ag

- Mepilex Transfer Ag combines a rapid antimicrobial effect within 30 min and a sustained effect up to 14 days (*in vitro* studies)[38]
- Minimise skin damage and pain at dressing changes[8, 39]

Mextra® Superabsorbent

- Superabsorbent dressing with fluidrepellent backing
- For highly exuding wounds
- Superabsorbent particles for high absorption and retention[40]
- The superabsorbent particles in the pad have a protease modulating activity[41-43]
- Soft and conformable
- Fluid repellent backing layer protects against fluid strike-through

Granulox®

- Granulox is a hemoglobin-based spray for topical use on chronic wounds
- The hemoglobin provides the wound with the required oxygen by means of diffusion
- Twice as many chronic wounds healed at 8–16 weeks compared to standard of care[44-46]
- Granulox is easy to handle and to apply

Granudacyn®

- Wound irrigation solution and gel for acute and chronic wounds such as venous leg ulcers
- Effective preservation with HOCl/ NaOCl against gram+/- bacteria, viruses, fungi and spores[47]
- Reduce wound malodor[48]

Tubifast

- Tubular retention bandage
- Holds dressings securely, without constriction or compression
- A variety of lengths are available
- Available in a range of quick reference, colour-coded sizes to fit everything from small limbs to adult trunks

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Please note: This is a Guide only and cannot replace clinical judgement. Each clinician is responsible for comprehensive evaluation and a plan of care appropriate for individual patient needs.

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