NHS
Central London
Clinical Commissioning Group

Leg Ulcers

Should not be referred to dermatology unless skin cancer, pyoderma gangrenosum or vasculitic ulcers are suspected (see below)

Please refer to the tissue viability nurses or vascular surgeons depending on clinical findings

Suspected malignancy

- either BCCs of SCCs can initially masquerade as a venous ulcer
- They may improve slightly in compression bandaging but over a longer period the non-healing nature becomes apparent
- Other signs of cancer
    - Bleeding from ulcer
    - Overgrowth of tissue at edge of ulcer
    - Unusual site
    - Lack of skin changes normally associated with venous ulcers

Suspected pyoderma gangrenosum or vasculitic ulcers

- Look for:
    - Purple raised or inflamed edge
    - Unusual site
    - Rapid onset
    - Painful ulceration where ABPI's are normal
    - Underlying associated conditions (i.e. inflammatory bowel disease, rheumatoid arthritis, haematological malignancy)

Varicose eczema

- Treatment tips
    - Apply compression
    - Avoid potential allergens (i.e. topical antiseptics, topical antibiotics, parabens, a preservative in most paste bandages)
    - If weeping – Potassium Permanganate (Permitabs) soaks 1 in 8000 strength as a soak for 10 minutes daily and Betnovate RD cream (not to the ulcer itself) for 2-3 days
    - If dry – Betnovate RD ointment
    - Reduce potency to Hydrocortisone or Eumavate ointment as eczema improves
    - If persistent despite treatment – refer for patch testing