GCPHN – Wound Workshop

Untangling Leg Ulcer Aetiology and Complex Wound Management

Gold Coast University Hospital & Griffith University

Declaration…

HOW DO WE HEAL LEG ULCERS ?

DELIVER NUTRIENTS
SUPPLY O2
CLEAR TOXINS

HOW DO WE HEAL LEG ULCERS ?

DELIVER NUTRIENTS
SUPPLY O2
CLEAR TOXINS
REMOVE EXCESS FLUID

BLOOD FLOW

HOW DO WE HEAL LEG ULCERS ?

DELIVER NUTRIENTS
SUPPLY O2
CLEAR TOXINS
REMOVE EXCESS FLUID

BLOOD FLOW

So, All Ulcers are **VASCULAR**

Why else? – cost imperatives

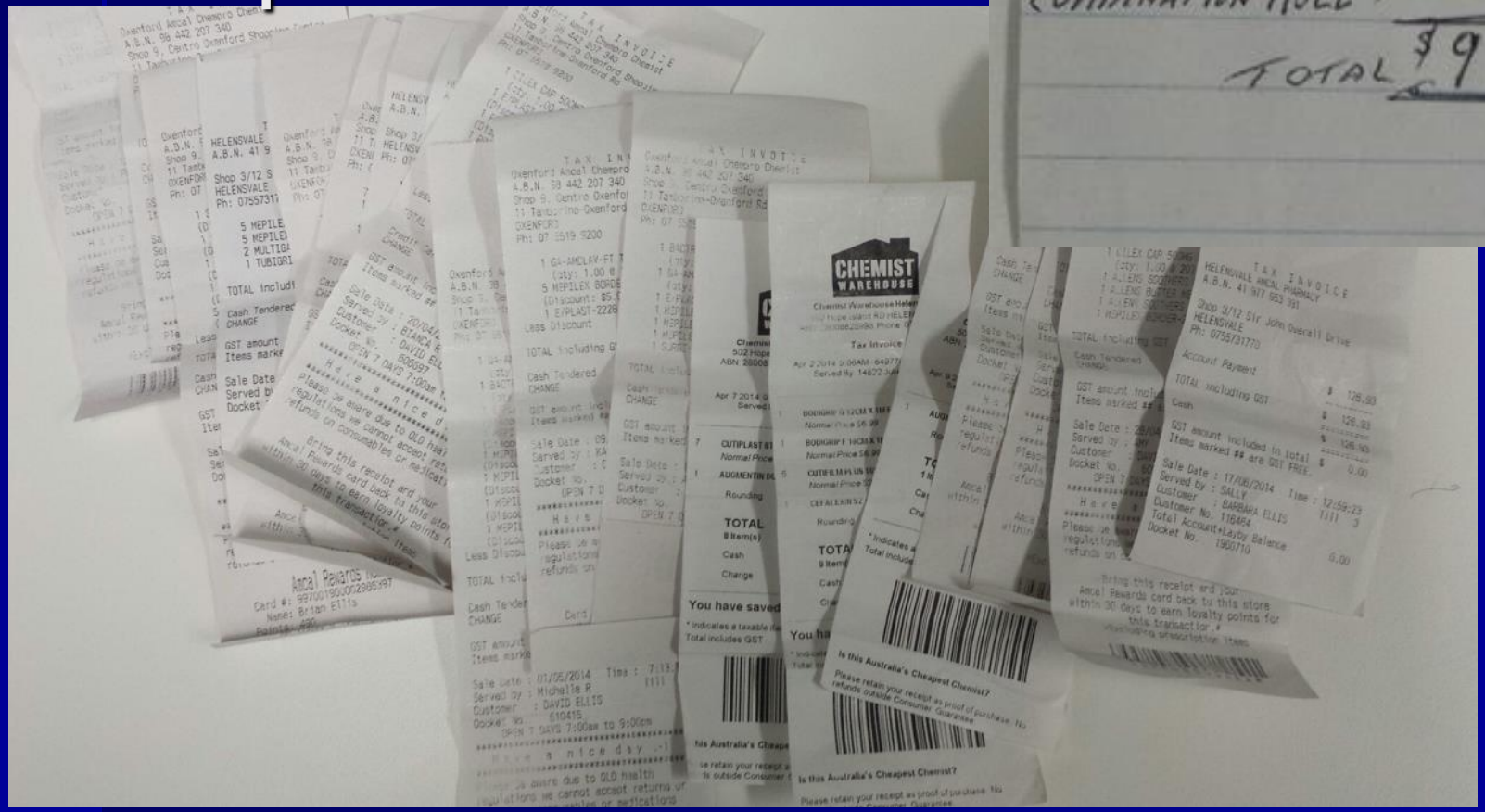
Why else? – cost imperatives

5 months – insidious onset.

Venous ulcer

Receipts
Monthly costs
A$980

MEPILEX TWICE DAILY 7 DAYS $140
4 × 140 IE MONTH $560
+ APPROX $60
BACTOBAN OINTMENT
ANTIBIOTICS
TUBULAR STOCKING
COMBINATION ROLL
$420
TOTAL $980



Ineffective wound care - 2

- 34yo
- Ulceration: 3 months
- Unable to work.

Poor management - 2

- 34yo
- 3months ulceration. Unable to work.
- Dressings – erratic protocol
- 6 courses of antibiotics
- "Regular appointment on Friday afternoon for more antibiotics"
- Currently on Cipro & Septrin Forte

It gets worse…

- Plastics admission
  - Antibiotics of course!!
- Plan…
  - Plastic surgical Outpatients
  - Consider excision & skin grafting …

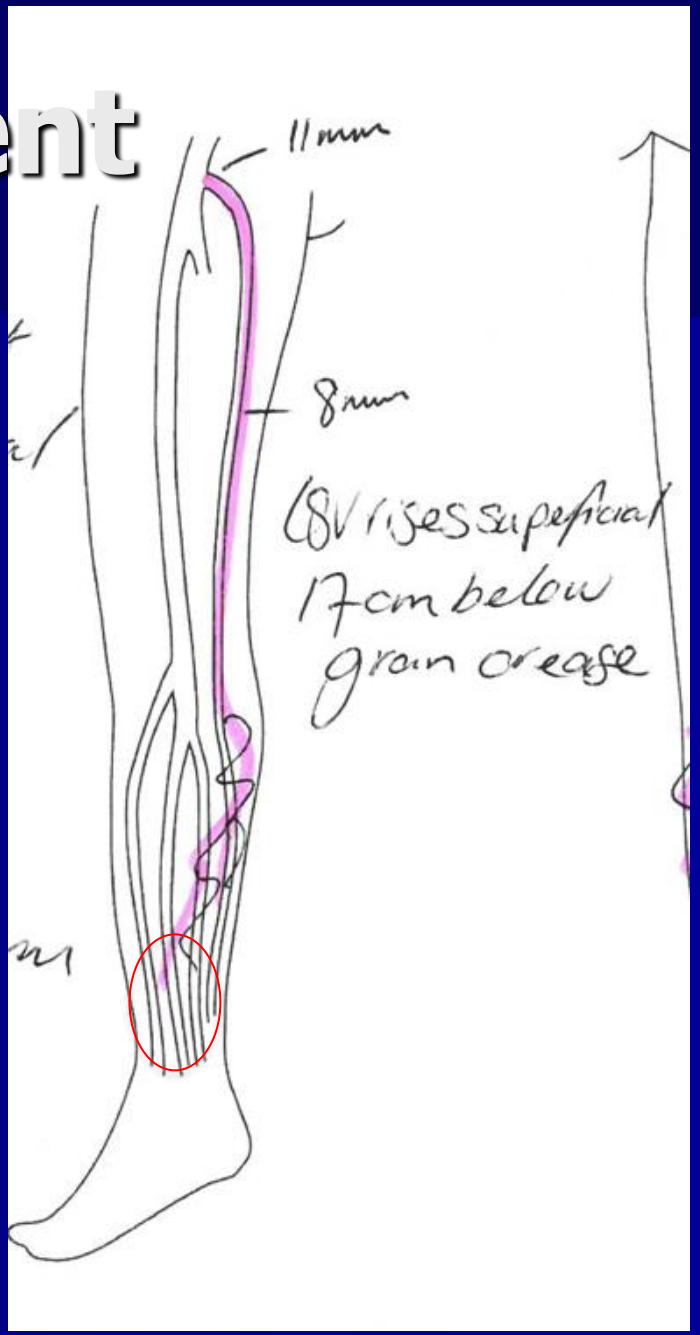
…advised to avoid stockings

Vascular assessment

- Before plastics …
- Clinically evident VV's

Vascular assessment

- Duplex assessment
- Large incompetent Great Saphenous vein
  - Leading all the way to the area of ulceration



Why else?
– Patient imperatives

Iatrogenic injury (Health-care associated)

Saphenous vein harvest

Diagnosis helps prevention… Pressure Ulceration

Why else?
– Patient imperatives

Iatrogenic injury
Health-care associated

Pressure injury

Compression

Why else?
– Patient imperatives

Iatrogenic injury
Health-care associated

Radiation skin injury

ULCER AETIOLOGY

- Venous
- Arterial
- Neuropathic
- Lymphoedema
- Others

ULCER AETIOLOGY

Venous

Arterial

Neuropathic

Lymphoedema

Others

Vasculitic

Iatrogenic/Trauma

Malignancy

Drug eruption

Congenital disorders

ULCER AETIOLOGY

Venous

Arterial

Neuropathic

ULCER AETIOLOGY

Venous

Arterial

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Lymphoedema

Others Vasculitic

Iatrogenic / Trauma

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Drug eruption

Congenital disorders

Mixed Aetiology

Increasingly aged population

Prevalence of Diabetes, Obesity & Renal failure / dialysis

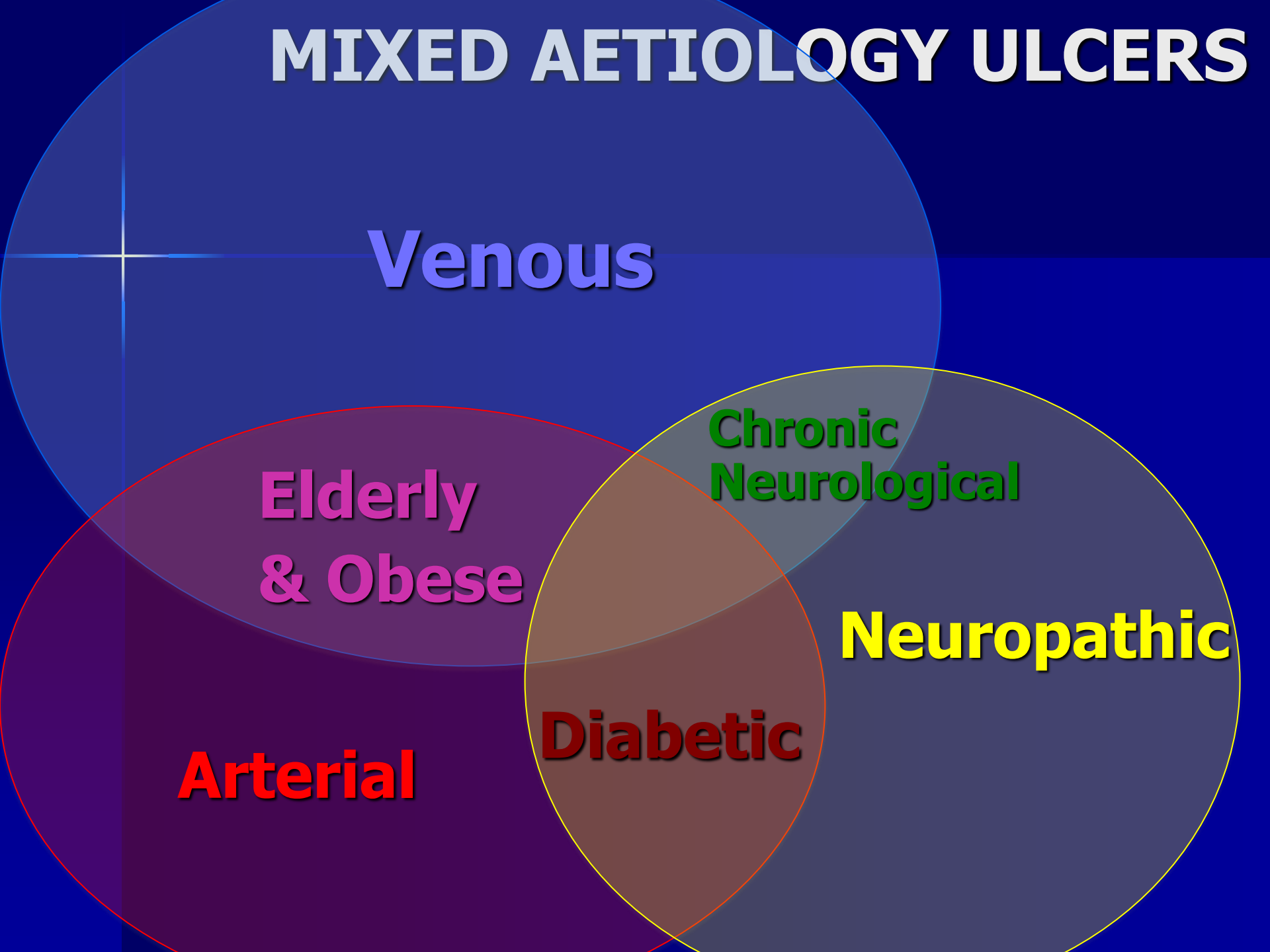
MIXED AETIOLOGY ULCERS

Venous

Arterial

Neuropathic

MIXED AETIOLOGY ULCERS



.....ULCER MANAGEMENT

Compression

Off-loading

Revascularisation

Diabetes: Silent Epidemic

The natural history of Type 2 Diabetes is characterised by a slow progression from a low-risk to high-risk State.

1) onset of ‘prediabetic’ changes in glucose metabolism
2) the prevalence of undiagnosed diabetes
3) eventual diagnosis of diabetes.

But, macrovascular complications commence long before during the threshold for diagnosis of diabetes

- occurs with normal HbA1C
- OGTT more diagnostic

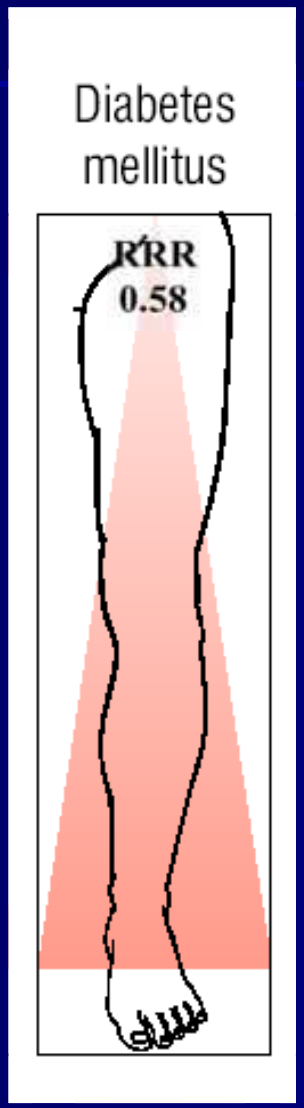
Neuropathy too.

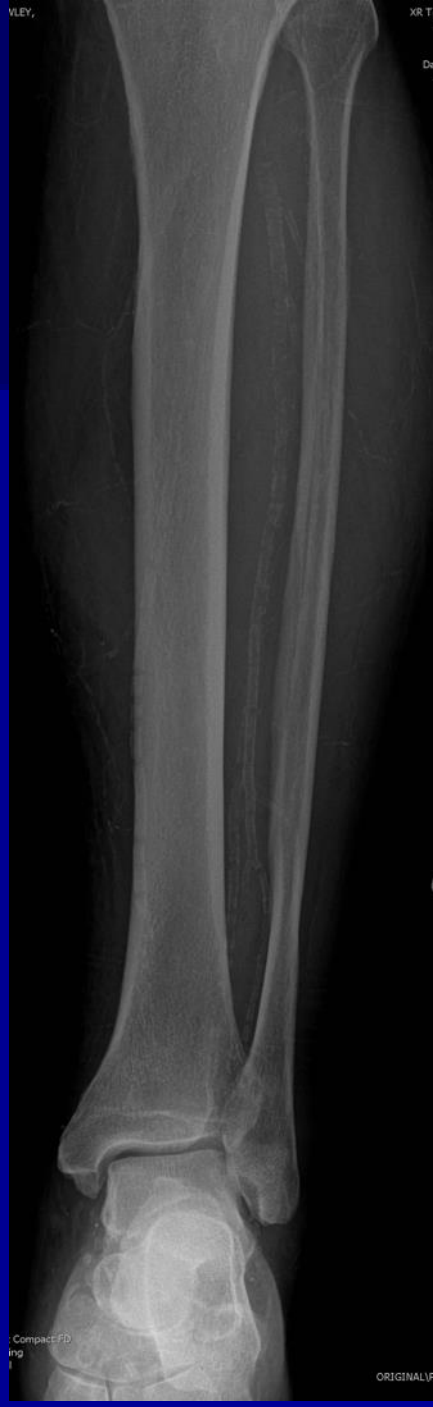
How does Diabetic Vascular Disease differ from atherosclerosis?

Affects younger patients (if poorly controlled)
No sex differences
Rapidly progressive
Increased calcification
Impaired Endothelial function
More distal vessels affected

Smaller vessels have poor outcomes in vascular surgery

Anatomical Patterns of Diabetic Vascular Disease





Small Vessel Disease – Calcification

Assessing the Diabetic Foot

- The "High-risk" diabetic foot
- Neuropathy (greatest contributor)
  - Sensory (pain, temperature stimuli)
  - Motor (intrinsic muscles –deformity)
  - Sympathetic (impaired autoregulation)
- Impaired immunity – specific bacteriology
- Impaired Vascularity
- Impaired Vision - Accidents / poor hygeine / awareness

The Diabetic Foot

- 7% of the Australian population T2 DM (2.3M)
- 15% develop a foot ulcer In lifetime (345,000)
- 500,000 hospital admissions and 12,000 deaths attributed to the condition in 2004 alone

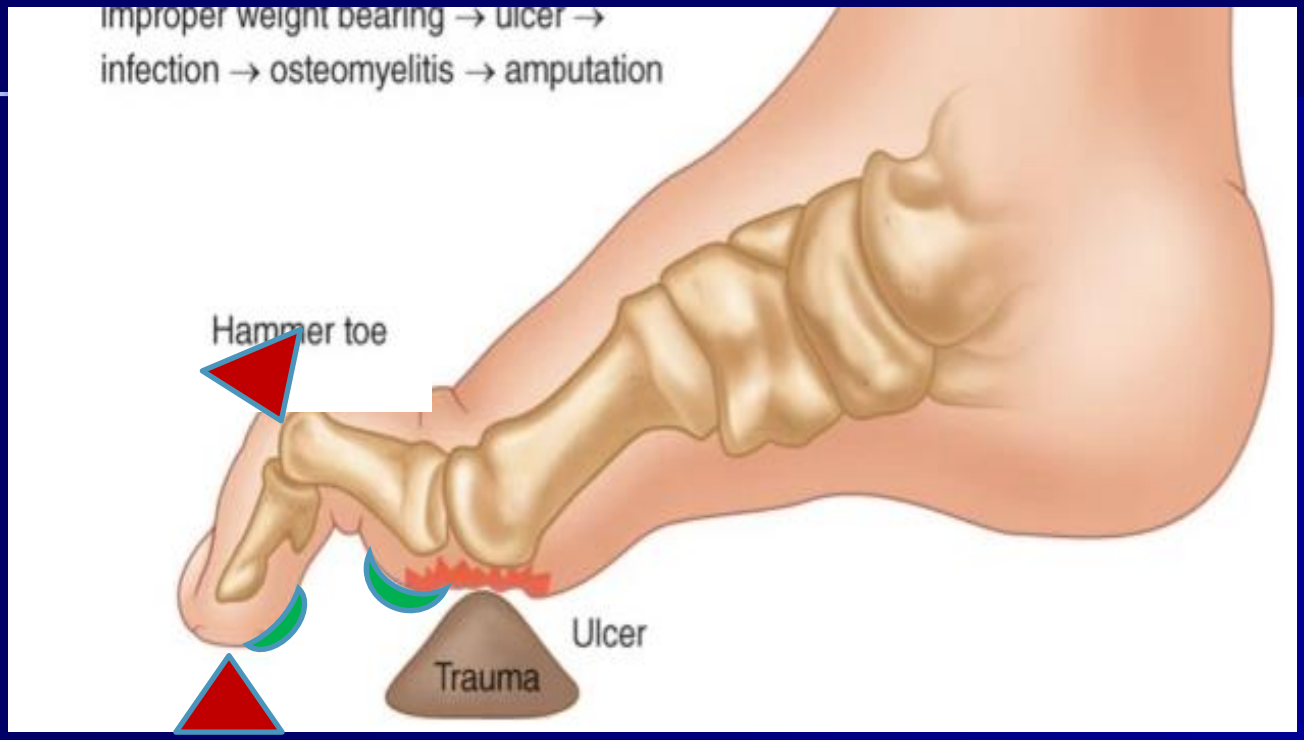
(Lazarrini 2012)

Those admitted with foot ulcer have:

Significant rates of limb amputation

Mortality risk

Neuropathy - deformities



The Gold Coast Diabetic Foot

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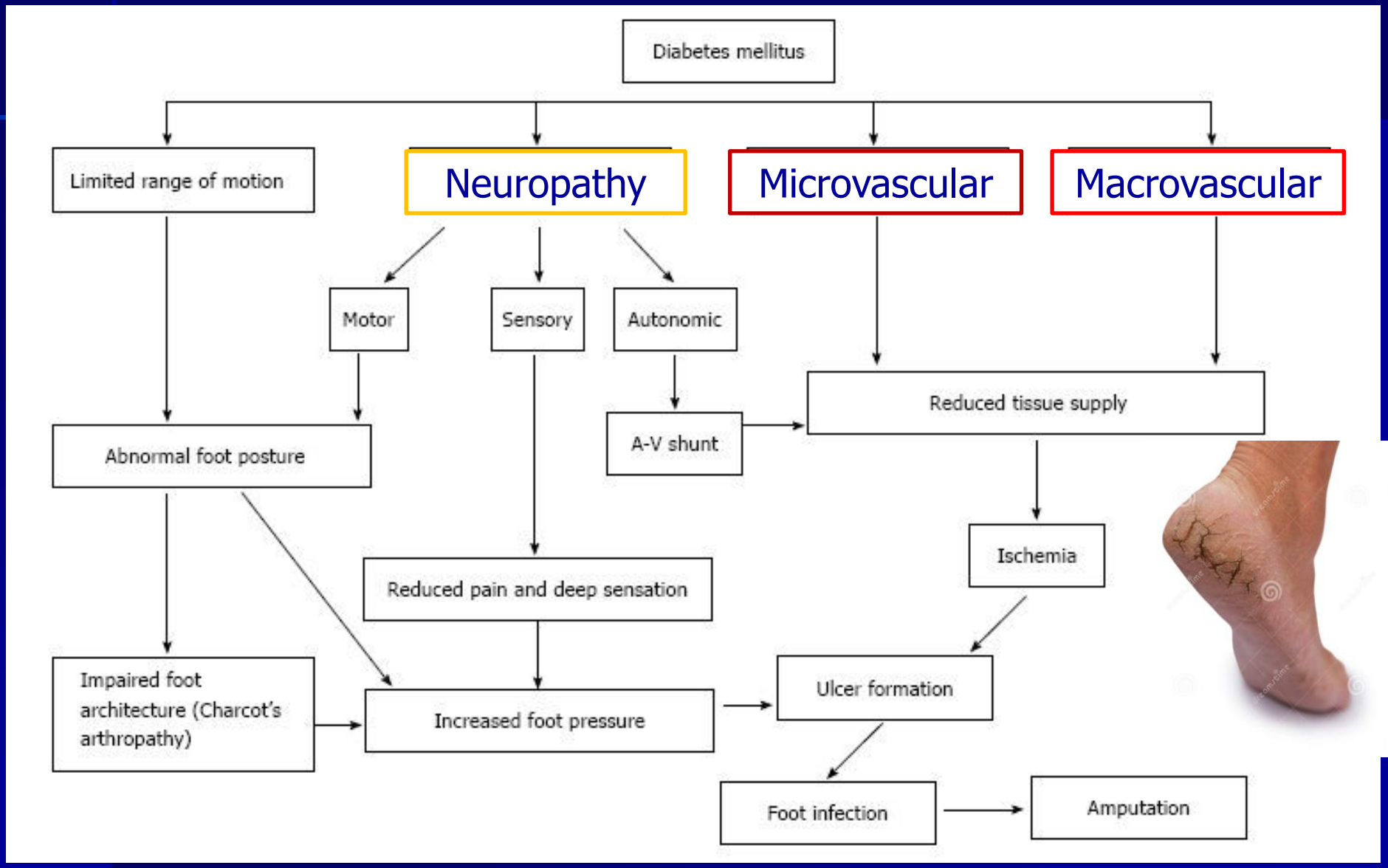
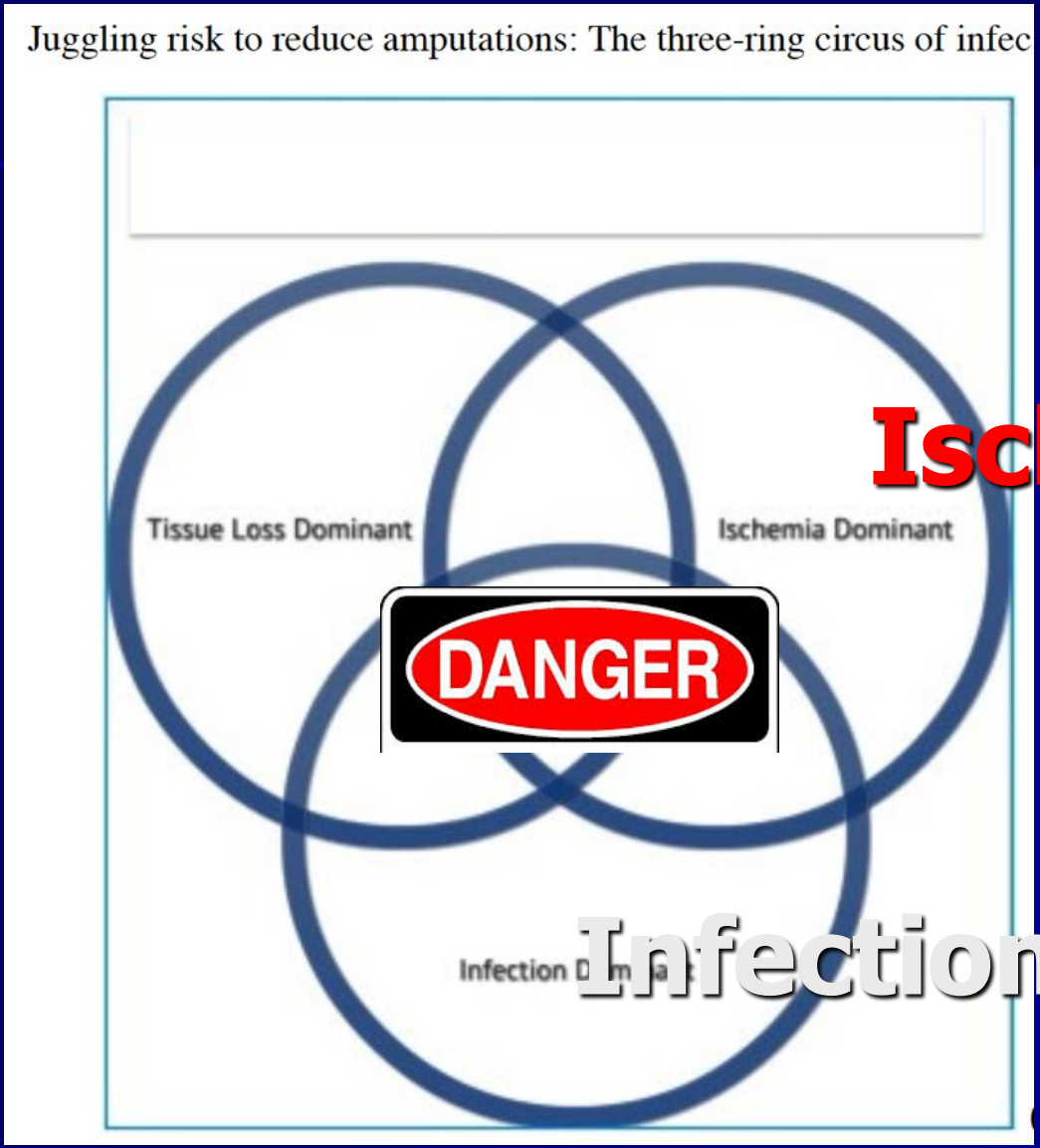
Diabetic Foot -Pathophysiology



3 Factors in Diabetic foot salvage

Wound

Ischaemia



"The stairway to amputation"

Major amputation

Sepsis

Acute Diabetic Foot

+ Vascular disease

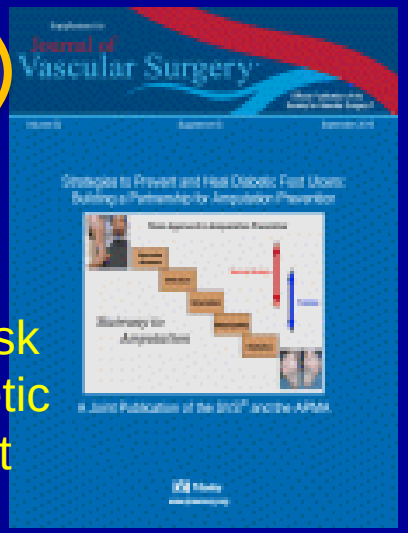
Foot Ulceration

High-risk Diabetic Foot

Neuropathy

At Risk Diabetic Foot

Diabetes / Metabolic Syndrome



Guidelines

DIABETES/METABOLISM RESEARCH AND REVIEWS
Diabetes Metab Res Rev 2016; **32**(Suppl. 1): 45–74
Published online in Wiley Online Library (wileyonlinelibrary.com) **DOI:** 10.1002/dmrr.2699

SUPPLEMENT ARTICLE

IWGDF guidance on the diagnosis and management of foot infections in persons with diabetes

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John Embil[5]
Shigeo Kono[6]
Lawrence Lavery[7]
Éric Senneville[8]
Vilma Urbančič-Rovan[9]
Suzanne Van Asten[7,10]
Edgar J. G. Peters[10]

Recommendations

Classification/diagnosis

1. Diabetic foot infection must be diagnosed clinically, based on the presence of local or systemic signs or symptoms of inflammation (strong; low).
2. Assess the severity of any diabetic foot infection using the Infectious Diseases Society of America/International Working Group on the Diabetic Foot classification scheme (strong; moderate).

Osteomyelitis

The Management of the Diabetic Foot

A Clinical Practice Guideline by the Society for Vascular Surgery in Collaboration with the American Podiatric Medical Association and the Society for Vascular Medicine

Journal of Vascular Surgery
February 2016 Supplement
Volume 63, Issue 2, Pages 3S–21S

SVS Society for Vascular Surgery

High-risk foot referral portal

https://www.goldcoast.health.qld.gov.au/referrals/conditions/high-risk-foot-vascular

High-risk foot (Vascular)

Adult

Vascular Surgery

On this page

Useful Management Information

- Diabetic foot ulcer: High-risk foot clinic (referral via podiatry and access via telehealth available -- Statewide Diabetes Clinical Network will provide details)
- For adults with diabetes, assess their risk of developing a diabetic foot problem at the following times:
  - when diabetes is diagnosed, and at least annually thereafter
  - if any foot problems arise
  - on any admission to hospital, and if there is any change in their status while they are in hospital.
- For low risk of developing a diabetic foot problem, continue to carry out annual foot assessments, emphasise the importance of foot care, and advise they could progress to moderate or high risk
- Basic foot care advice and the importance of foot care
- Aboriginal and Torres Strait Islander people with diabetes are considered to be at high risk of developing foot complications until adequately assessed otherwise
- Commence antibiotics as per therapeutic guidelines
  Off-loading
- Renal impairment increases the risk of amputation for people with diabetes who experience amputation rates 11 times that of the general diabetic population, which in turn is 15 times the rate in people without diabetes

Examine both feet for evidence of the following risk factors:

- Neuropathy (use a 10g monofilament as part of a foot sensory examination)
- Limb ischaemia (see CPC on peripheral arterial disease)
- Ulceration
- Callus
- Infection and/or inflammation
- Deformity
- Gangrene
- Charcot arthropathy

Minimum Referral Criteria

Send Referrals To

Smart Referrals
Preferred Method
About Smart Referrals

Secure Web Transfer
Send to: Gold Coast Health Service District

Internal Referrals
Vascular Surgery (E-Blueslips)

Fax
(07) 5687 4497

Post
Booking and Referral Centre
Gold Coast University Hospital
1 Hospital Boulevard
Southport QLD 4215

Enquiries
1300 559 083

Service Availability

Dr Venu Bhamidi

Facilities
Gold Coast University Hospital
Robina Hospital

If you would like to send a named referral, please address it to the specialist listed above, who will allocate a suitably qualified specialist to see the patient. Alternatively, you can view a full list of our specialists.

Diabetic foot infection

Assessing diabetic foot ulcers for infection

The International Working Group on the Diabetic Foot [Note 1] and the Infectious Diseases Society of America [Note 2] advise t
ulcer to be considered infected, **at least two** of the following features should be present:

- local swelling or induration
- erythema extending more than 0.5 cm in any direction from the wound
- local tenderness or pain
- local warmth
- purulent discharge.

Other causes of inflammation (eg trauma, gout, thrombosis) should be considered.

Culture of tissu
may identify org
from noninfecte

Do not collect

Infection severi
Diabetic Foot [I

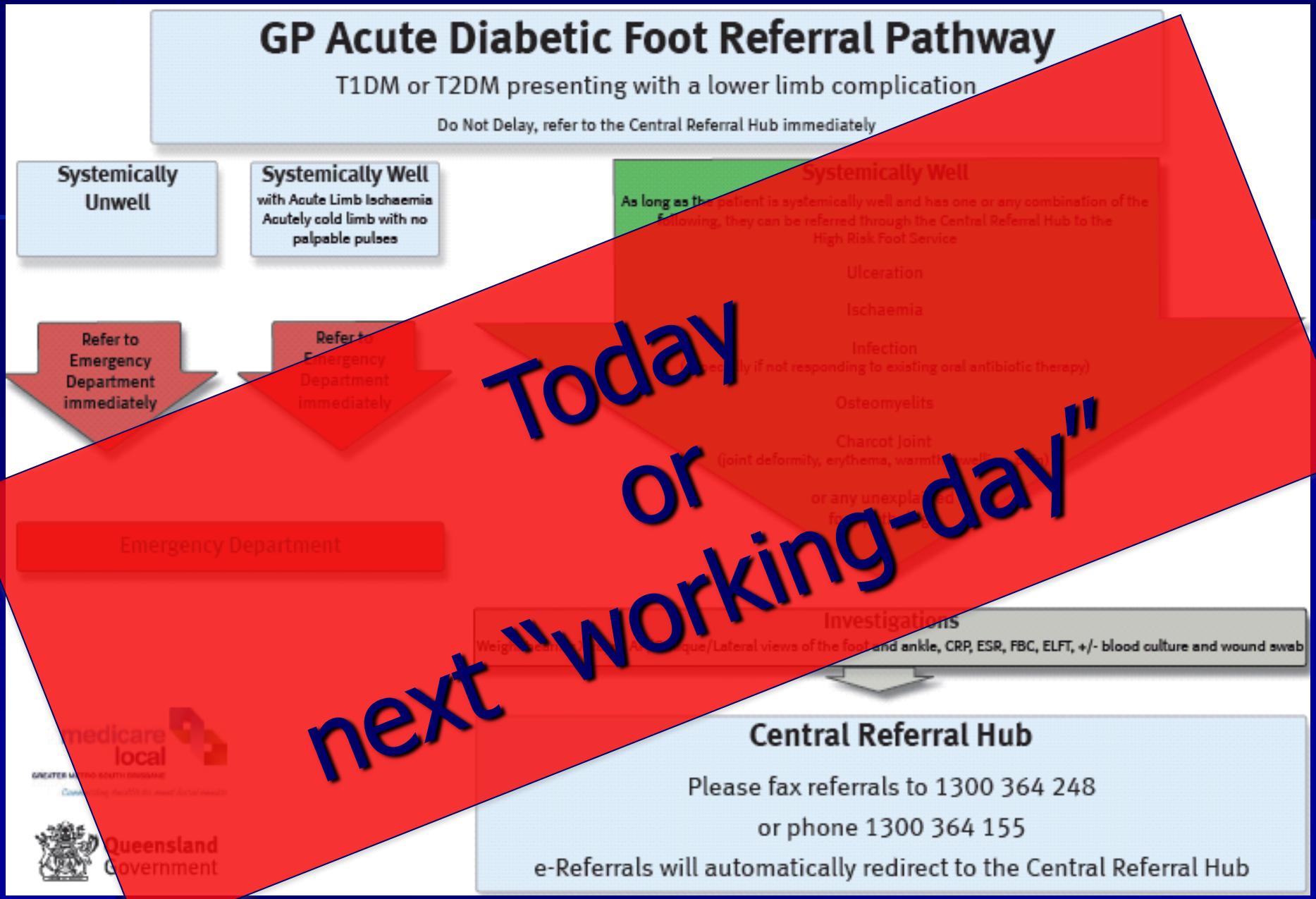
- mild diab
  margin a
- moderat
  erythema
  syndrom
- severe d
  abnorma
  breaths/

Note 1: Lipsky E
with diabetes. Di

Infection severity determines antibiotic choice. The following severity scoring system is supported by the International Working Group on the Diabetic Foot [Note 1] and the Infectious Diseases Society of America [Note 2]:

- mild diabetic foot infection involves only the skin and subcutaneous tissue. Erythema extends no more than 2 cm from the wound margin and there are no systemic features of infection
- moderate diabetic foot infection involves structures deeper than the skin or subcutaneous tissues (eg muscle, bone, joint, tendon) or erythema that extends more than 2 cm from the wound margin. Infection is not associated with systemic inflammatory response syndrome (SIRS) (as described below)
- severe diabetic foot infection is an infection associated with systemic inflammatory response syndrome (SIRS) (ie 2 or more of: abnormal temperature [more than 38°C or less than 36°C]; heart rate more than 90 beats/minute; respiratory rate more than 20 breaths/minute; white cell count more than 12×10^9/L or less than 4×10^9/L, or more than 10% immature [band] forms).

Note 2: Lipsky BA, Berendt AR, Cornia PB, Pile JC, Peters EJ, Armstrong DG, et al. 2012 Infectious Diseases Society of America clinical practice guideline for the diagnosis and treatment of diabetic foot infections. Clin Infect Dis 2012;54(12):e132-73. [URL]


GP Acute Diabetic Foot Referral Pathway
T1DM or T2DM presenting with a lower limb complication
Do Not Delay, refer to the Central Referral Hub immediately
Systemically Unwell
Systemically Well
with Acute Limb Ischaemia
Acutely cold limb with no palpable pulses
Systemically Well
Ulceration
Ischaemia
Infection
Osteomyelits
Charcot Joint
Refer to Emergency Department immediately
Emergency Department
Investigations
and ankle, CRP, ESR, FBC, ELFT, +/- blood culture and wound swab
Central Referral Hub
Please fax referrals to 1300 364 248
or phone 1300 364 155
e-Referrals will automatically redirect to the Central Referral Hub
Today
or
next "working-day"
medicare local
Queensland Government

WOUND MANAGEMENT PRIORITIES

- Determine Viability
- Drain Sepsis
- Ensure Vascular Supply
- Treat Infection
- Determine Aetiology
- Debridement
- Granulation / Wound Contracture
- Epithelisation
- Prevention

Extent of infection?

Look for tracking of sepsis

Needs drainage

Temporising measures

Drain pus / open tracts / joint cavities

HIERARCHY of PRIORITIES- A Vascular Surgeon's Perspective

- Determine Viability
- Drain Sepsis
- Treat Infection
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- Prevention

DETERMINE AETIOLOGY

- History.
  - Pain:

severe	Arterial
moderate	Vasculitic
mild	Venous
None	Neuopathic

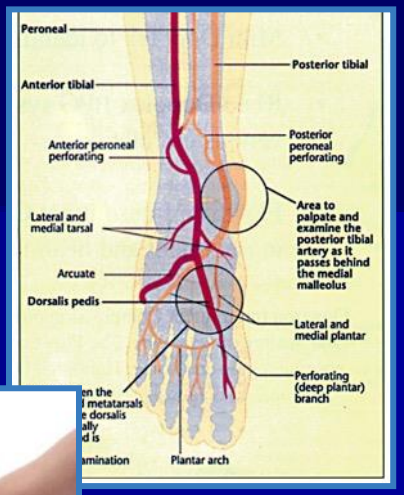
- Examination — Co-existent signs
  Peripheral pulses.
- Pathology.
  - Biopsy. (Unusual & chronic wounds)
- Radiology.

Arterial assessment

- Determine aetiology
- Plan revascularisation (deliver 02)
- Avoid injury
- Apply compression when revascularization required.

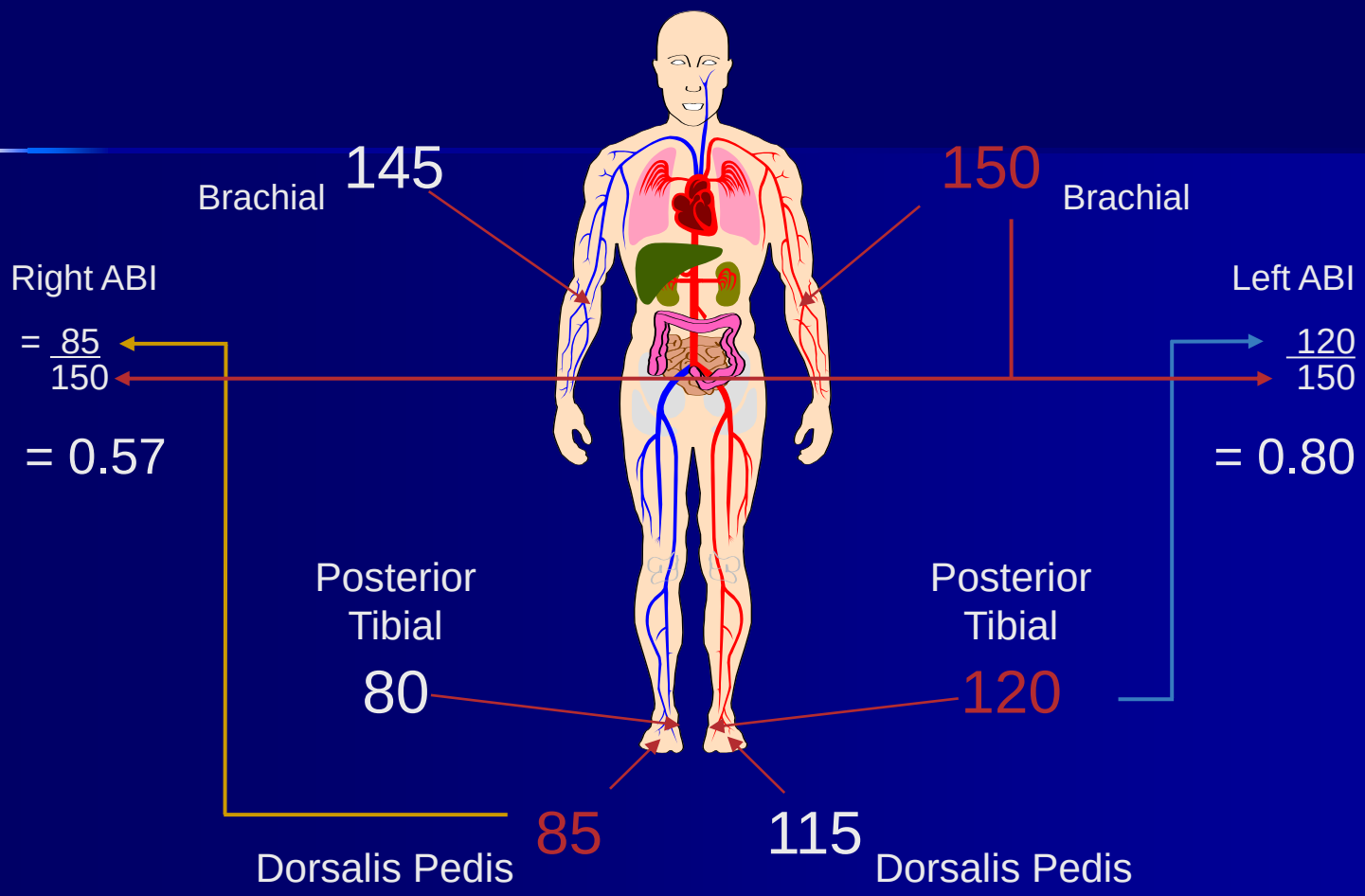
Non-invasive assessment techniques

- Peripheral pulses and bruits
- Ankle brachial index (Doppler)
- Doppler velocity waveform
- Duplex ultrasound scanning
- Magnetic resonance angiography



Belch JJF *et al. Arch Intern Med* 2003; 163: 884-92.; TASC Working Group. *J Vasc Surg* 2000; 31: S1-S296.

How to calculate the ABI



Belch JJF *et al. Arch Int Med* 2003; 163: 884-92; Hiatt WR. *N Engl J Med* 2001; 344: 1608-21.

ABI values and clinical severity

Ankle-Brachial Index	Interpretation
>1.30	Non compressible
>0.90-1.30	Normal
0.41-0.90	Mild-to-moderate PAD
0.00-0.40	Severe PAD

Belch JJF *et al*. *Arch Intern Med* 2003; 163: 884-92; Hiatt WR. *N Engl J Med* 2001; 344: 1608-21.

Arterial Assessment – Caveat

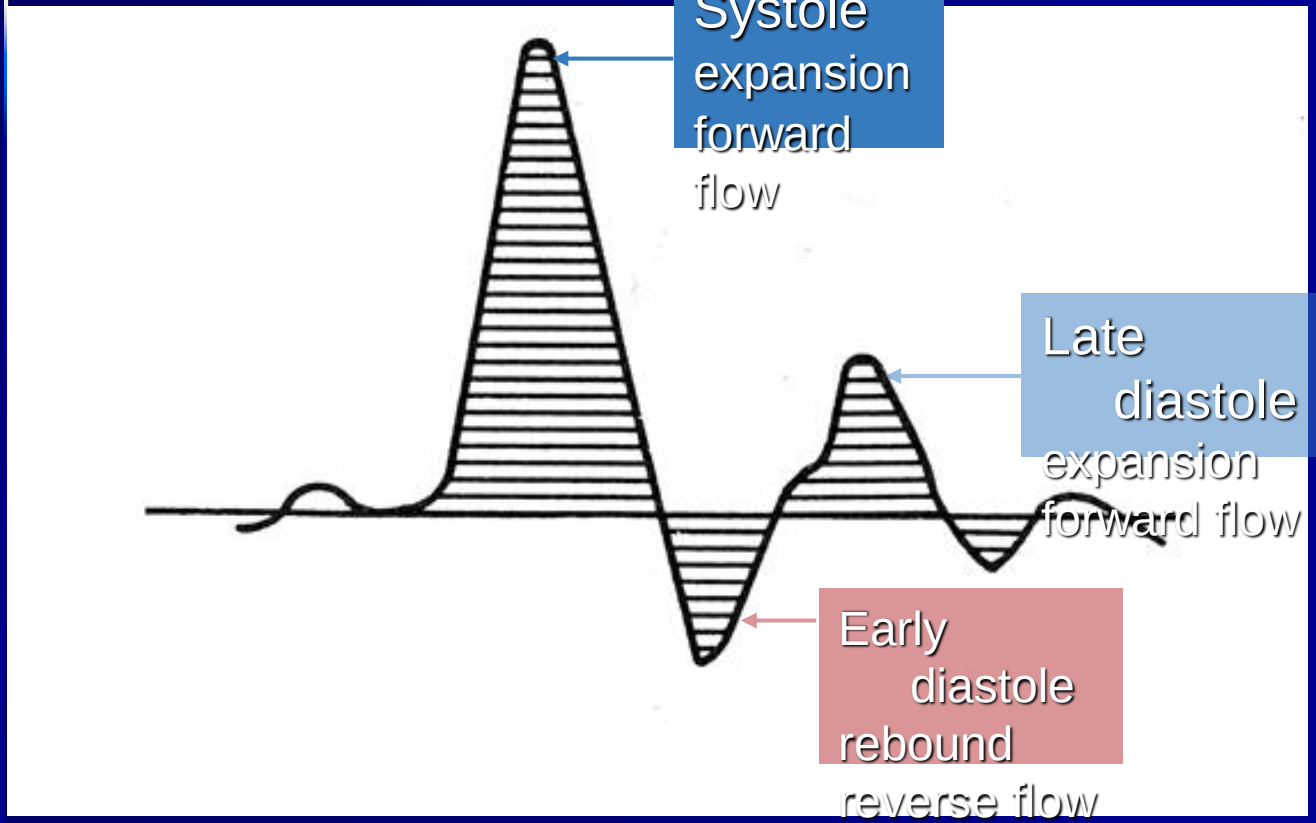
Ankle-Brachial Index Interpretation

>1.30 Non compressible

Nb. Calcified or non-compressible arteries may lead to falsely elevated ABI readings →

attempt toe-brachial index instead .

Haemodynamics

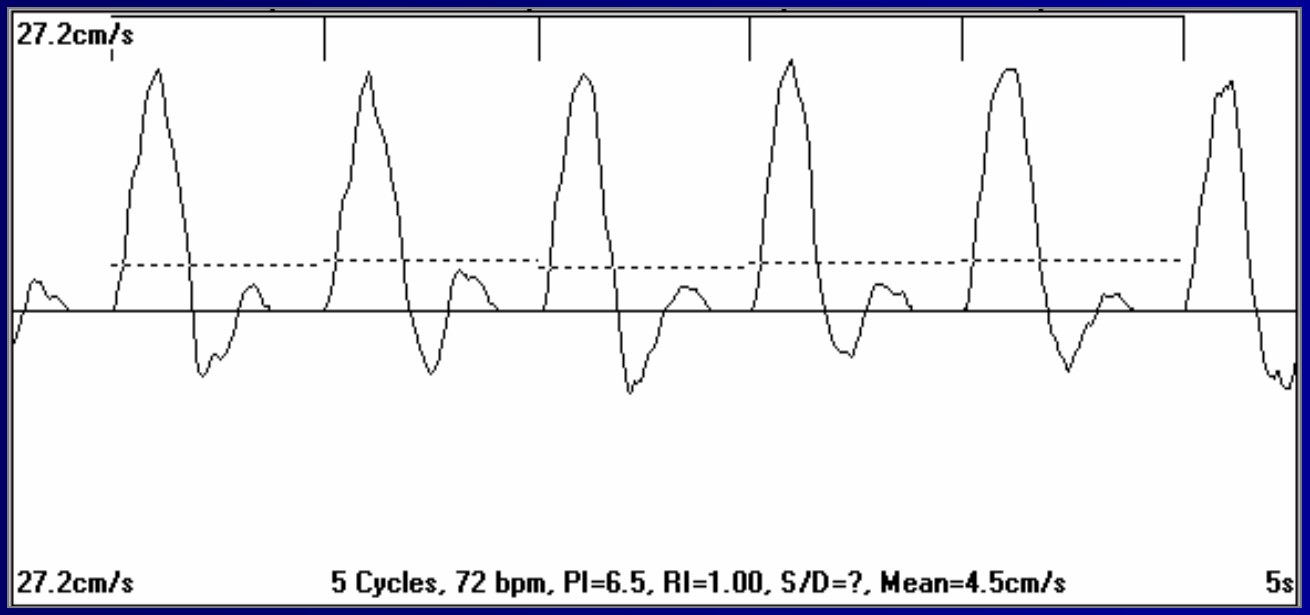


Zwiebel WJ, 1982; Aburahma AF, Diethrich ED, 1988.

Interpreting Doppler waveforms

Triphasic waveform

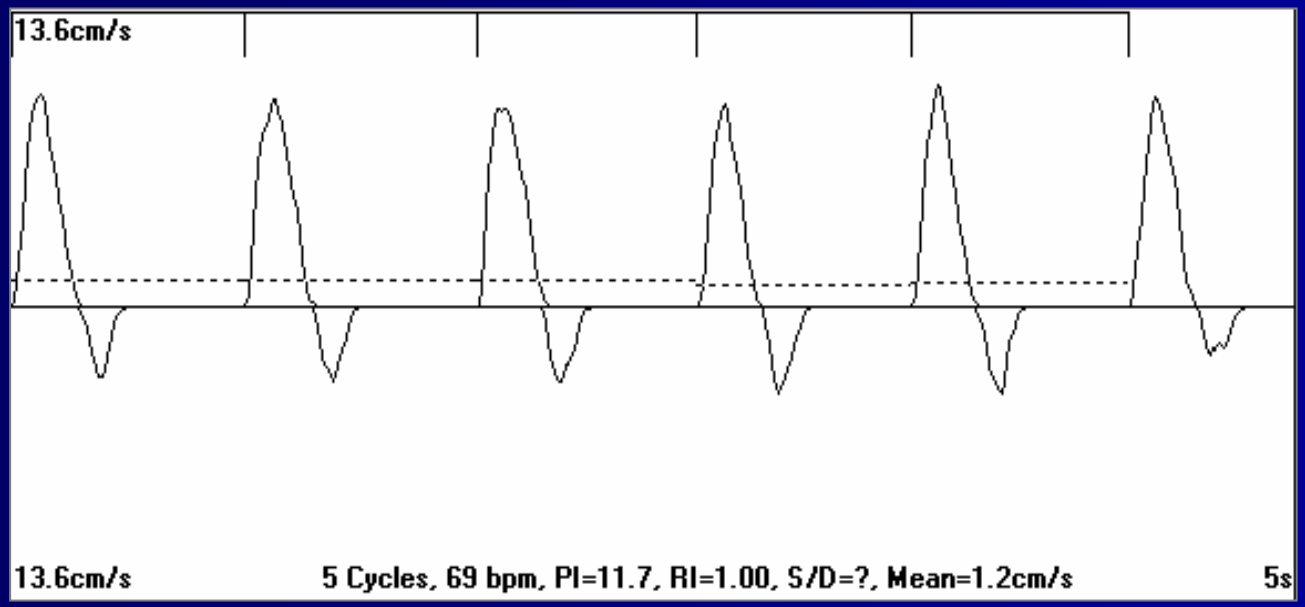
- Indicates normal blood flow



Interpreting Doppler waveforms

Biphasic waveform

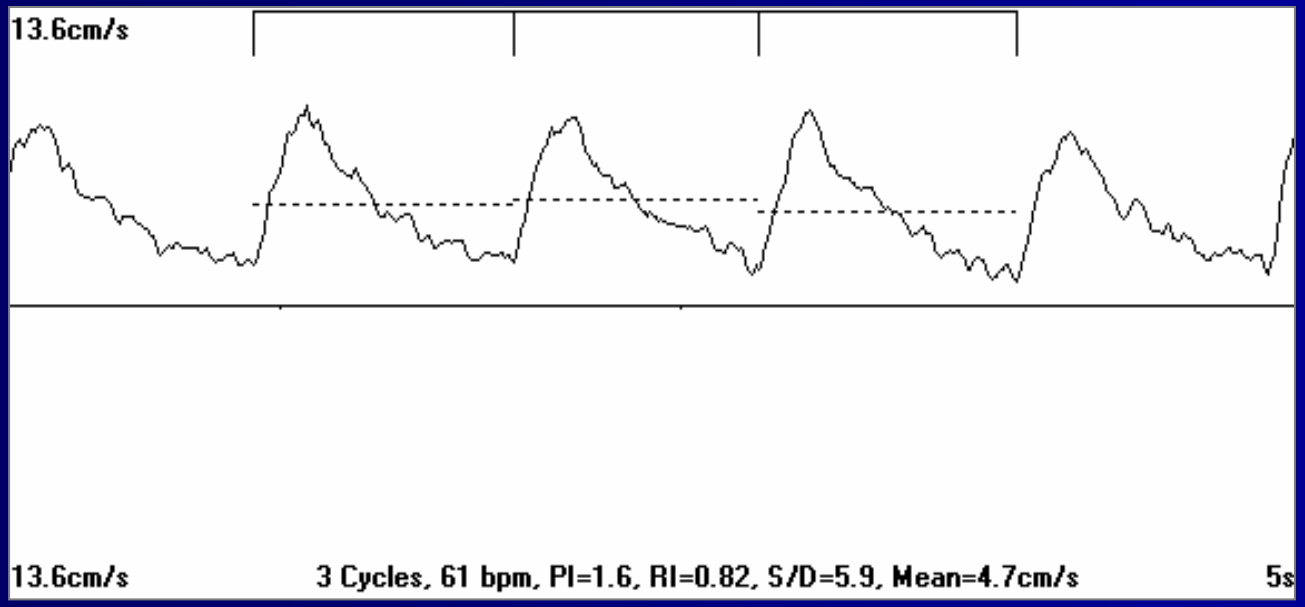
- Indicates mild-to-moderate flow impairment



Interpreting Doppler waveforms

Monophasic waveform

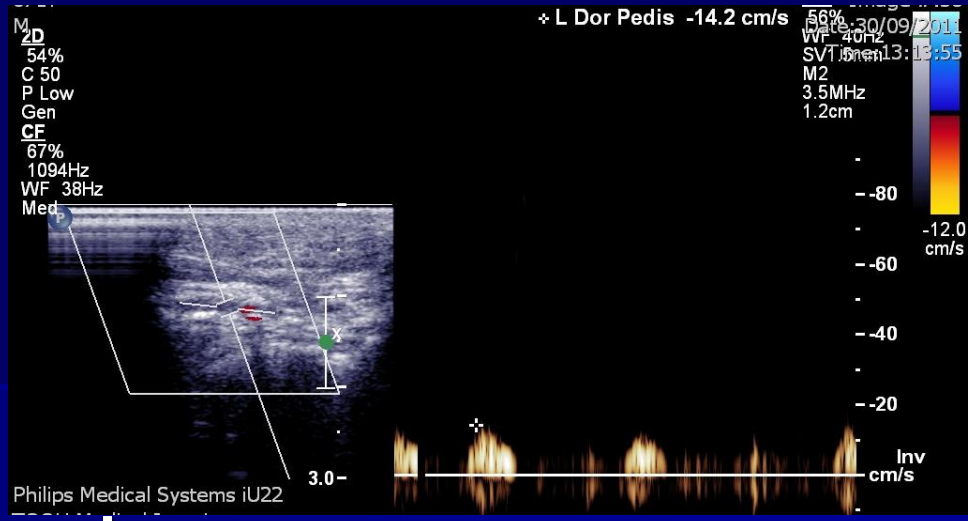
- Indicates severe flow impairment



Ultrasound (duplex)

- Non-invasive
- Cheap but time consuming
- Operator dependent- experience, enthusiasm
- Requester dependent
- Not good for fat people
- Calcified vessels difficult to insonate
- Calcific walls contribute to reverberation artefacts

Ultrasound (duplex)



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* Somewhat limited in advanced diabetic disease

CTA

- Expensive
- Iodinated contrast
- Radiation
- Scanner and operator dependent
- Very demanding to interpret
- Good for obese people
- Good for big vessels
- No good with calcium

CTA can be great

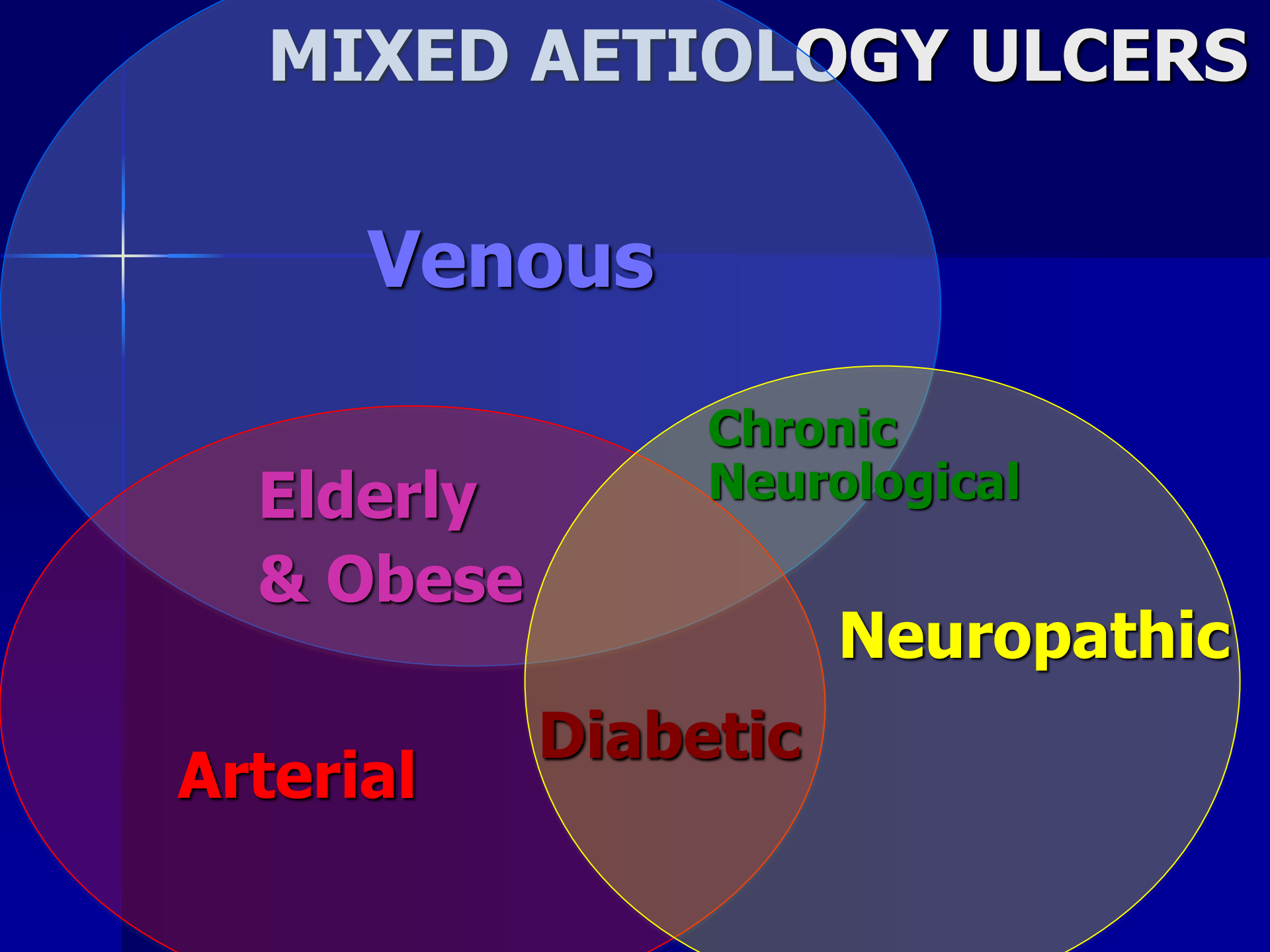
- normals
- no calcium
- good kidneys
- big vessels

…but CTA is no good when…

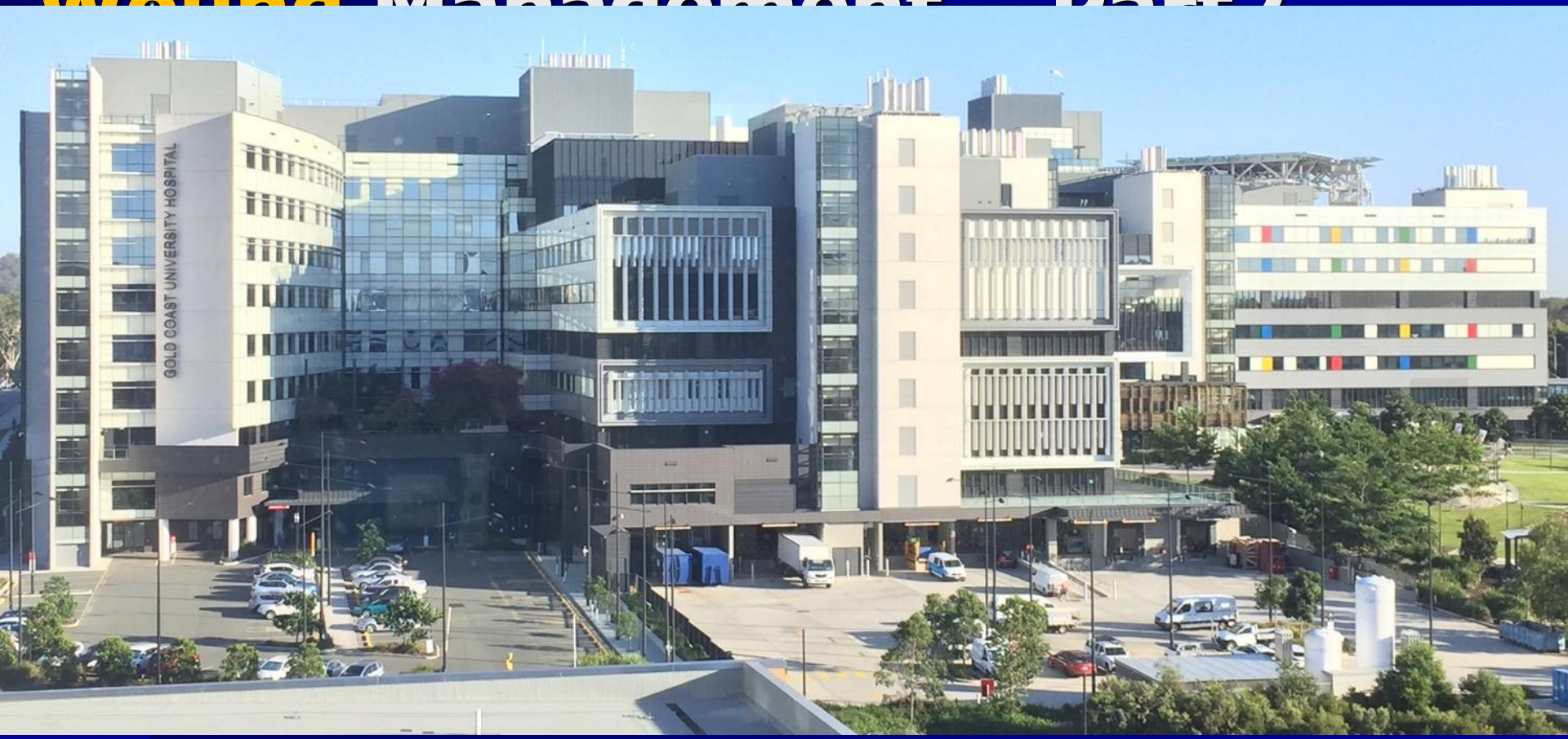
- calcified vessels
- small diameter vessels
- Renal issues
  (Iodinated contrast & frail kidneys)

* Very limited in advanced diabetic disease

MIXED AETIOLOGY ULCERS



Vascular & Complex Wound Management – Part2



Gold Coast University Hospital & Griffith University

HIERARCHY of PRIORITIES- A Vascular Surgeon's Perspective

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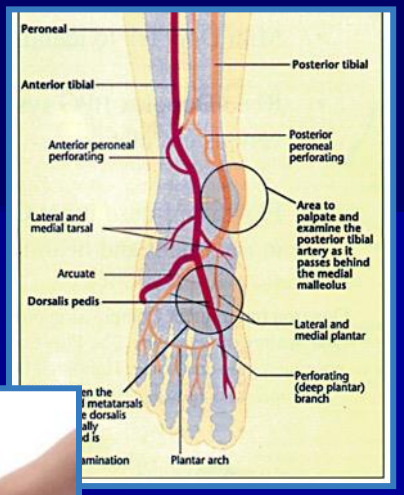


Belch JJF *et al. Arch Intern Med* 2003; 163: 884-92.; TASC Working Group. *J Vasc Surg* 2000; 31: S1-S296.

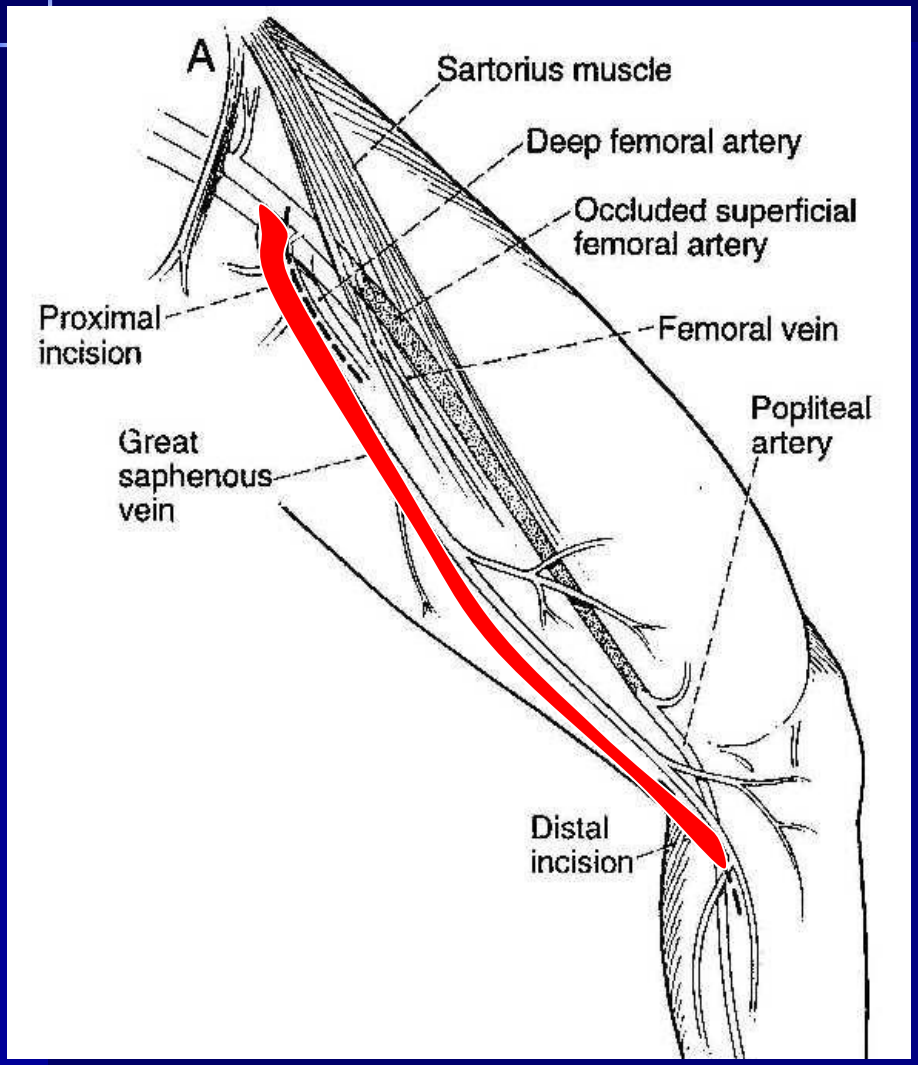
Revascularisation. What options do we have?

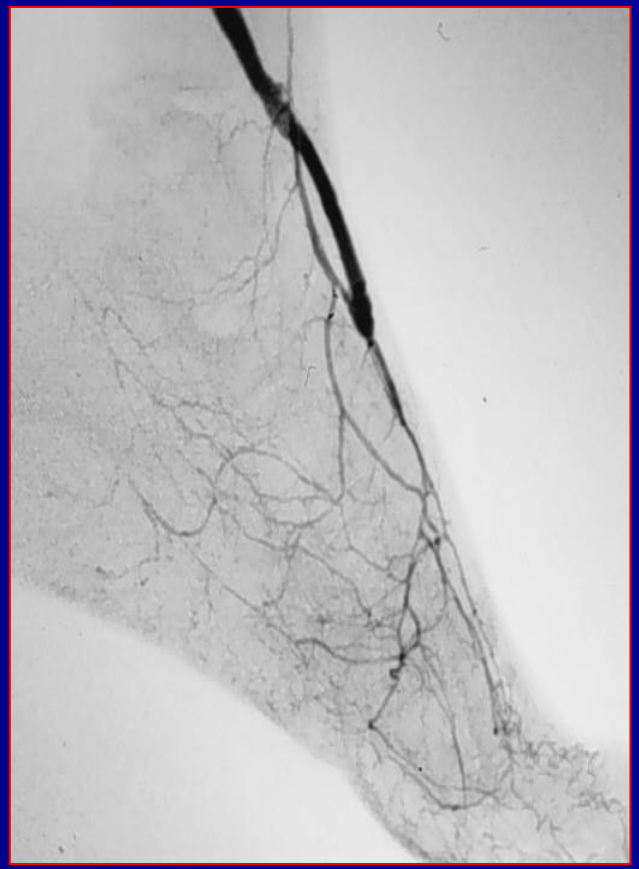
Leg ulceration or tissue loss

?

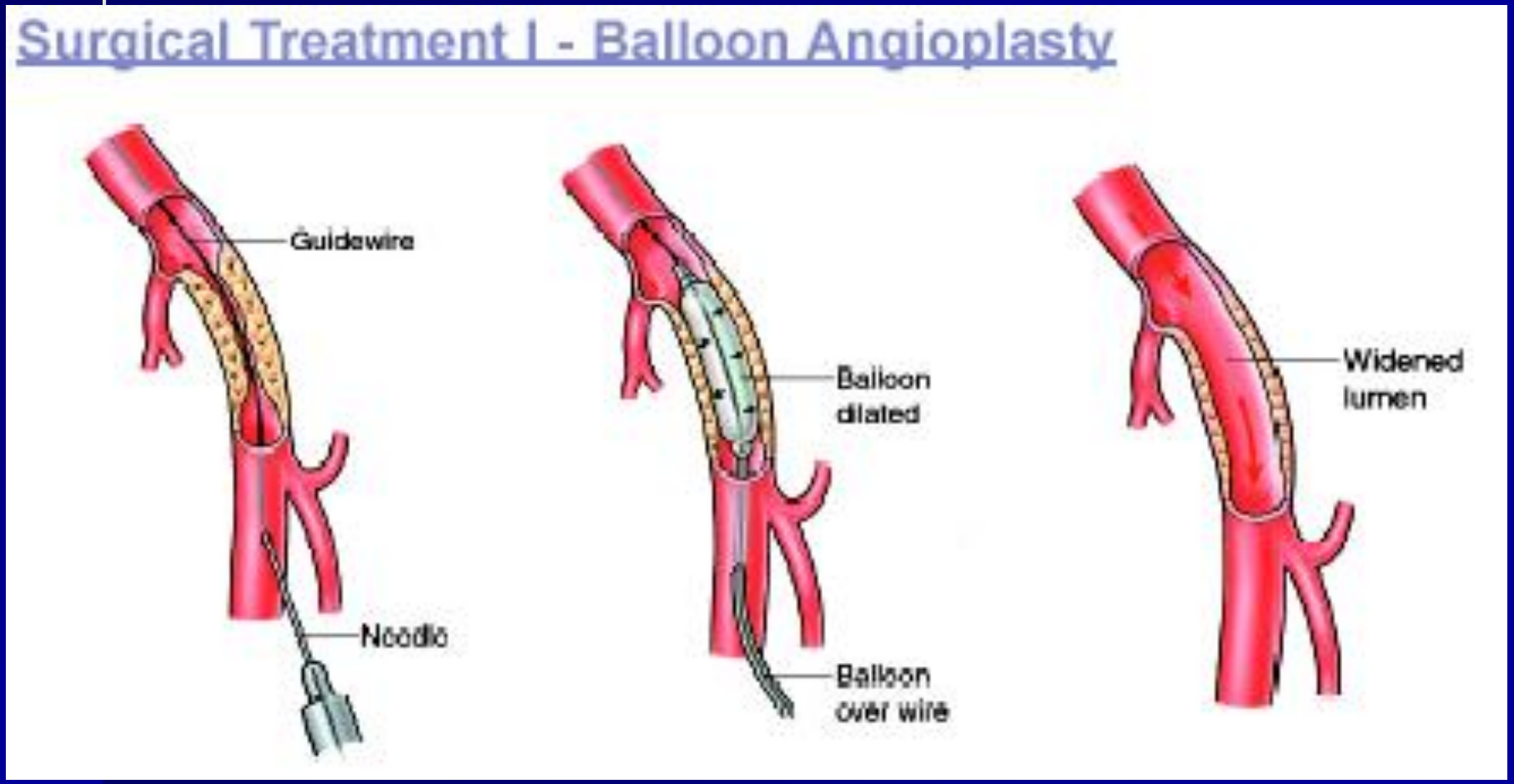
- Conservative
- Angioplasty / Stent
- Bypass
- Primary Amputation
- Palliation

Bypass for Lower Limb Revascularisation

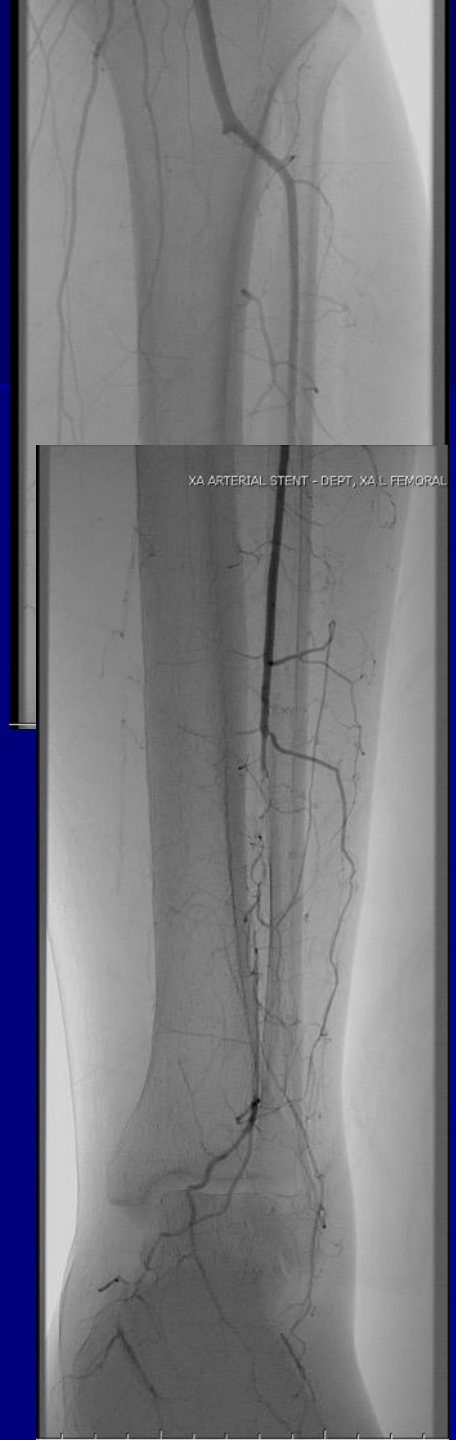


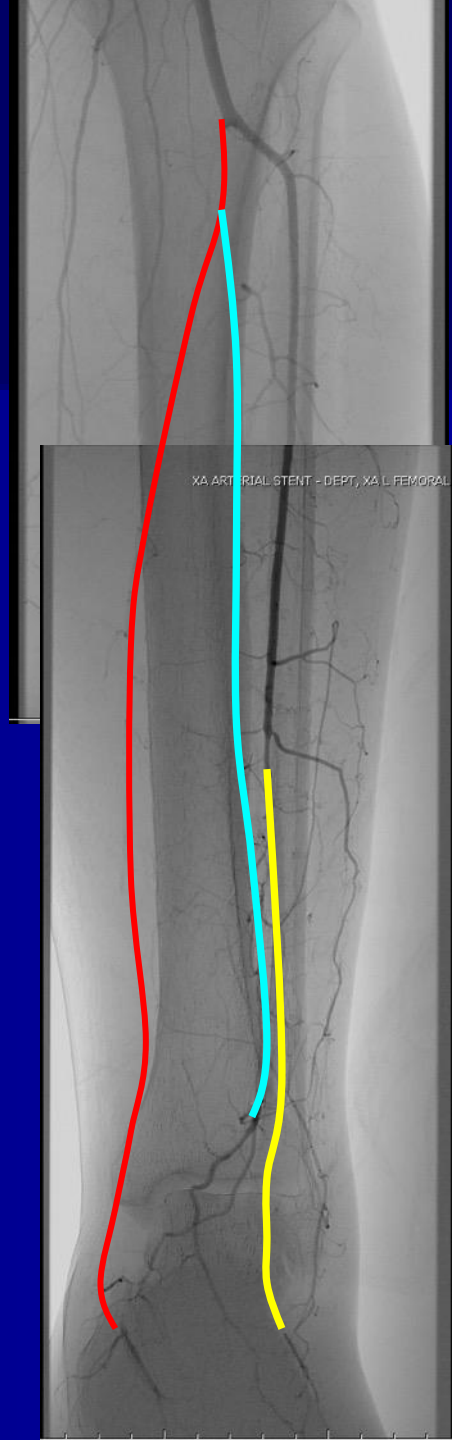


MANAGEMENT- Endovascular



Diabetic Macrovascular Disease (DSA)



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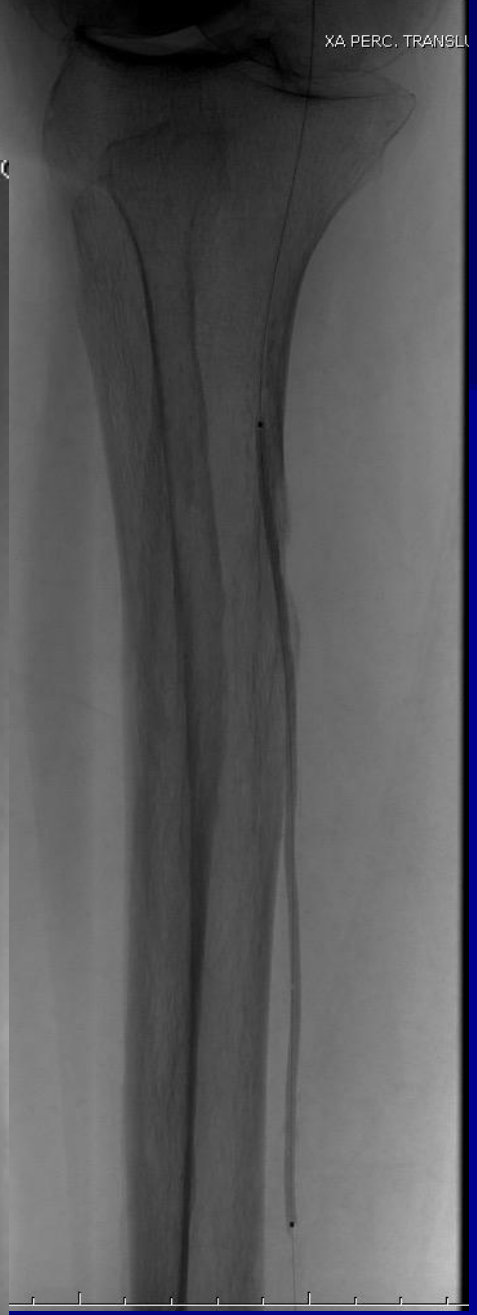
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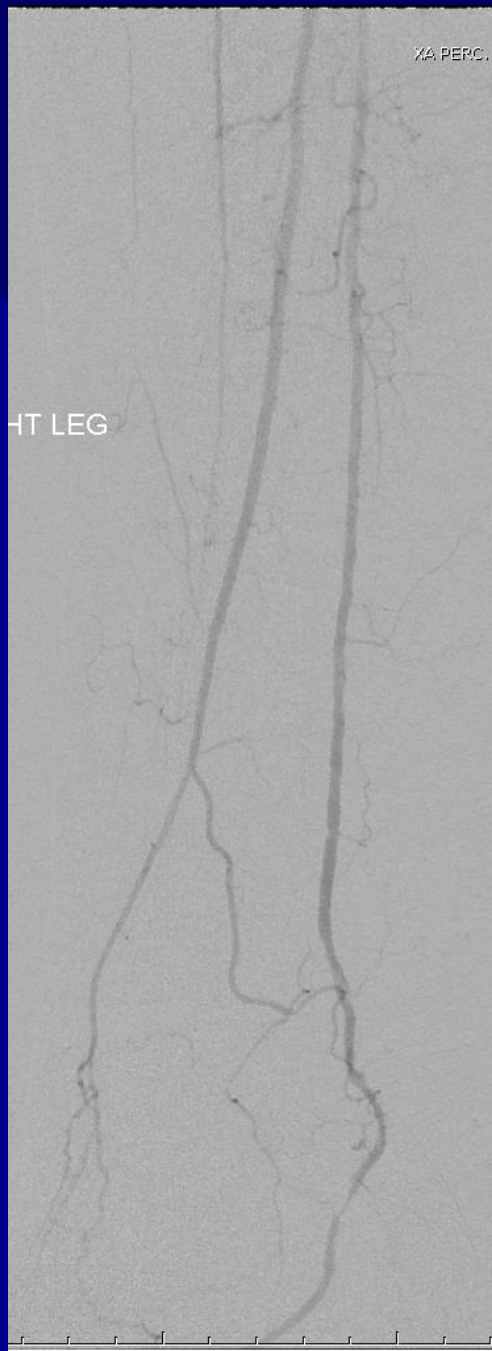

XA PERC.
HT LEG

Endovascular Facilities.

Expensive Resource - intensive

- *Shorter adm.*
- *Recovery of function.*
- *Healing*
- *Less pain*

VENOUS ULCER

- SITE- near medial or lateral malleolus.
- APPEARANCE- flat shallow margins, variable size,heavily exuding.
- PERIWOUND- stasis dermatitis, scale,maceration.

VENOUS LEG

- Staining of lower leg.
- Induration of ankle.
- Ankle flare - distended small venules on the medial aspect of foot.
- Oedema.
- Friable skin.
- Stasis dermatitis.

SIGNS OF VENOUS INSUFFICIENCY

Stasis changes

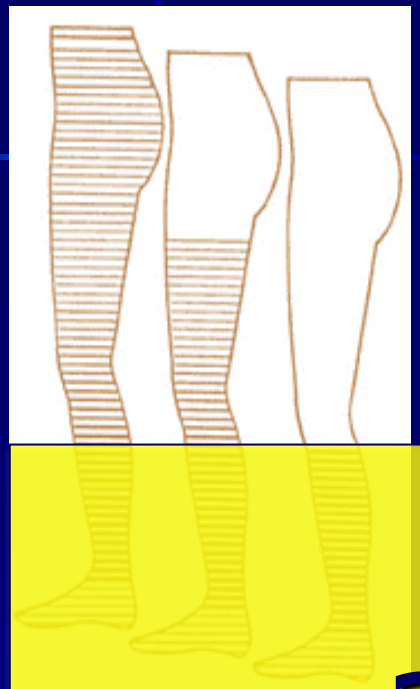
Precursor to Ulceration

- Haemosiderin
- LipoSclerosis (soft tissues)
- Dermatosclerosis
- Venous Flares / spiders
- Oedema

Massive Varicose Veins

Venous stasis oedema

Compression Therapy



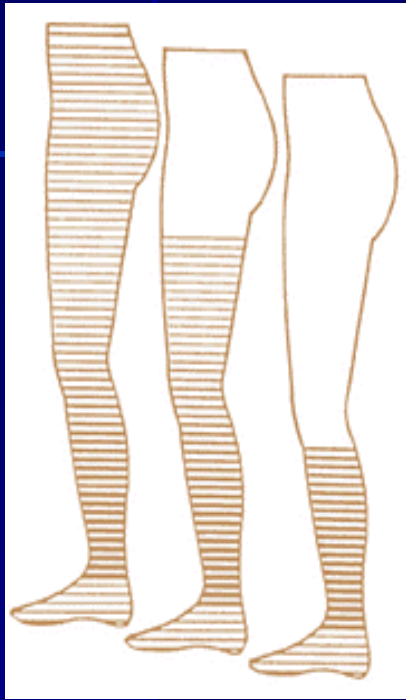
Compression Bandaging	Compression stockings
Tubular (retention dressing)	TEDS
Multi-layer Tubular	Grade 1 (15-20mmHg)
3-layered bandage	elderly / intolerant
Variable stretch bandage	
4-layered bandage	Grade 2 (20-30mmHg)
Gradual introduction	preferred
Short-stretch bandaging	Grade 3 (25-35mmHg)
	Compliance is difficult

Bed-bound

Compliance
?Reason – Fitting
Wearing
Removing

Venous stasis eczema / ulceration & cellulitis

Compression Therapy



Compression Bandaging

Tubular (retention dressing)

Multi-layer Tubular
3-layered bandage
Variable stretch bandage

4-

Compression stockings

TEDS — Bed-bound

Grade 1 (15-20mmHg)
elderly / intolerant

Grade 2 (20-30mmHg)
preferred
aids can be employed

Grade 3 (25-35mmHg)
compliance is difficult

Forced compliance!

Compression Therapy

Compression Bandaging	Compression stockings
Tubular (retention dressing)	TEDS Bed-bound
Multi-layer Tubular 3-layered bandage Variable stretch bandage	Grade 1 (15-20mmHg) elderly / intolerant
4-layered bandage Specialised Nursing Graduated compression	Grade 2 (20-30mmHg) preferred aids can be employed
Short stretch bandaging	Grade 3 (25-35mmHg) Compliance is difficult

Need to check pulses and ABPI's

ABI values and grade of compression.

Ankle-Brachial Index			Interpretation
>1.30			Non compressible
>0.90-1.30			Normal
	ABPI 0.8 - 0.9	Compress	
0.41-0.90	ABPI 0.6 - 0.8	Light	Mild-to-moderate PAD
	ABPI 0.4 – 0.6	No compression	
0.00-0.40			Severe PAD

Belch JJF *et al*. *Arch Intern Med* 2003; 163: 884-92; Hiatt WR. *N Engl J Med* 2001; 344: 1608-21.

Overview of leg ulcer assessment and compression therapy (Figure 15.6) [NB1]

PRESENTATION: LEG ULCER

Assessment
- history
- examination
- investigations
- ABPI
- arterial or venous scan

General management
- standard ulcer care
- **refer for correction of venous hypertension**
- review factors affecting wound healing
- manage pain
- review nutrition
- exercise
- manage oedema (elevate legs)
- skin care
- involve and educate patient
- risk factor modification

DIAGNOSIS

Venous ulcer
(no evidence of arterial disease, ABPI 0.8 to 1.3)

Mixed ulcer
(venous and arterial)
ABPI between 0.5 and 0.8

Mixed ulcer
(venous and arterial)
ABPI 0.5 or less, or above 1.3

Arterial ulcer
(no venous disease)

Other ulcers
(eg vasculitic or neuropathic ulcers, pyoderma or malignancy)

RECOMMENDATIONS

CLASS III COMPRESSION
(30 to 40 mmHg) [NB1]

NO

Any **precautions** for compression therapy present (eg peripheral neuropathy, infection, inability to report complications)?

Compression must only be prescribed by an appropriately trained professional.

YES

CLASS II COMPRESSION
(20 to 29 mmHg)

NO COMPRESSION
(vascular referral)

- specialist assessment (eg dermatologist)
- disease-specific treatment
- compression for oedema (if appropriate)

COMPRESSION OPTIONS

Patient mobile
- short stretch (inelastic)
- multicomponent
- compression hosiery
- long stretch (elastic)
- compression wraps

Patient immobile / fixed ankle
- multicomponent
- compression hosiery
- long stretch (elastic)
- intermittent pneumatic compression

- 3-layer tubular system
- reduced multicomponent compression
- compression hosiery

THERAPEUTIC OUTCOME

HEALED
maintenance compression for obstruction and/or deep venous insufficiency: 30 to 40 mmHg, or, for other patients or if not tolerated: 20 to 29 mmHg

SLOW OR NO HEALING DESPITE COMPRESSION
- review diagnosis and factors affecting wound healing
- refer back to vascular specialist

UNABLE TO TOLERATE
- try other options within the same class
- use intermittent pneumatic compression
- use reduced compression

Need to check pulses and ABPI's

Never compress an Arterially Compromised Limb

Evidence for Venous intervention

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Randomized Trial of Early Endoveno Ablation in Venous Ulceration

Manjit S. Gohel, M.D., Francine Heatley, B.Sc., Xinxue Liu, Ph.D., Andrew Bradbury, M.D., Richard Bulbulia, M.D., Nicky Cullum, Ph.D. David M. Epstein, Ph.D., Isaac Nyamekye, M.D., Keith R. Poskitt, M.D Sophie Renton, M.S., Jane Warwick, Ph.D., and Alun H. Davies, D.Sc. for the EVRA Trial Investigators*

ABSTRACT

BACKGROUND

Venous disease is the most common cause of leg ulceration. Although comp therapy improves venous ulcer healing, it does not treat the underlying cause nous hypertension. Treatment of superficial venous reflux has been shown to the rate of ulcer recurrence, but the effect of early endovenous ablation of superficial venous reflux on ulcer healing remains unclear.

METHODS

In a trial conducted at 20 centers in the United Kingdom, we randomly assigned 450 patients with venous leg ulcers to receive compression therapy and undergo early endovenous ablation of superficial venous reflux within 2 weeks after randomization (early-intervention group) or to receive compression therapy alone, with consideration of

(M.S.G., F.H., A.H.D.) and Imperial Clinical Trials Unit (X.L., J.W.), Imperial College London, London, University of Birmingham, Birmingham (A.B.), Gloucestershire Hospitals NHS Foundation Trust, Gloucester (R.B., K.R.P.), the Medical Research Council Population Health Research Unit and the Clinical Trial Service Unit and Epidemiological Studies Unit, Nuffield Department of Population Health, University of Oxford, Oxford (R.B.), University

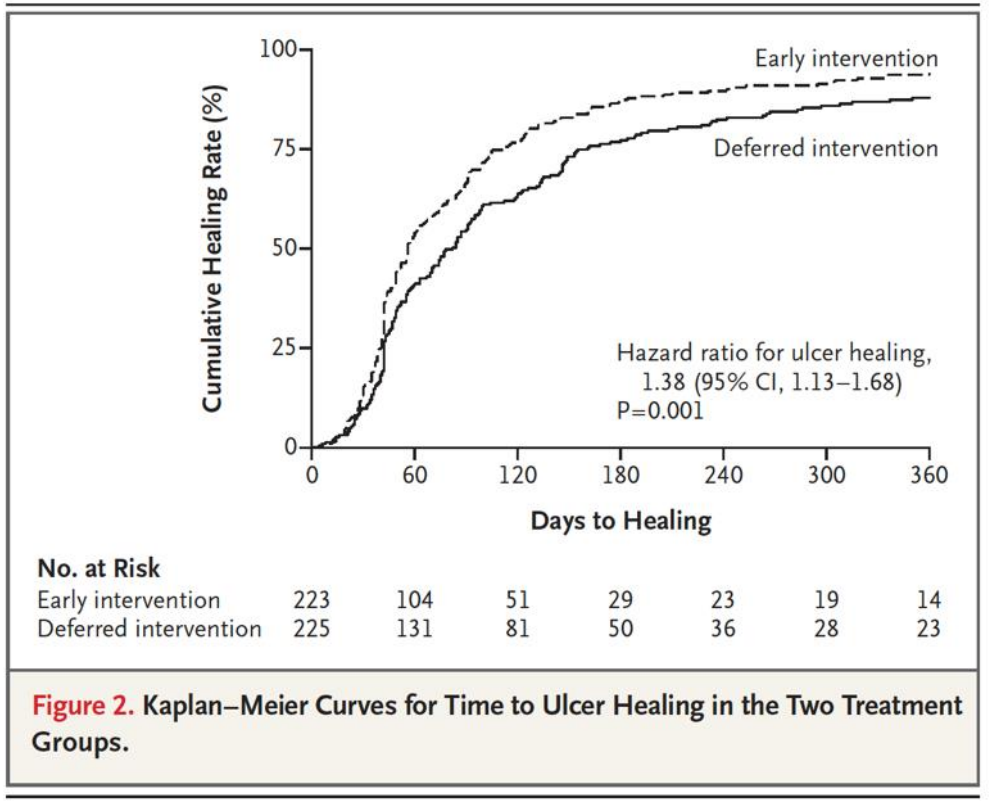


Figure 2. Kaplan–Meier Curves for Time to Ulcer Healing in the Two Treatment Groups.

Surgery & Endovenous Therapies

Radiofrequency

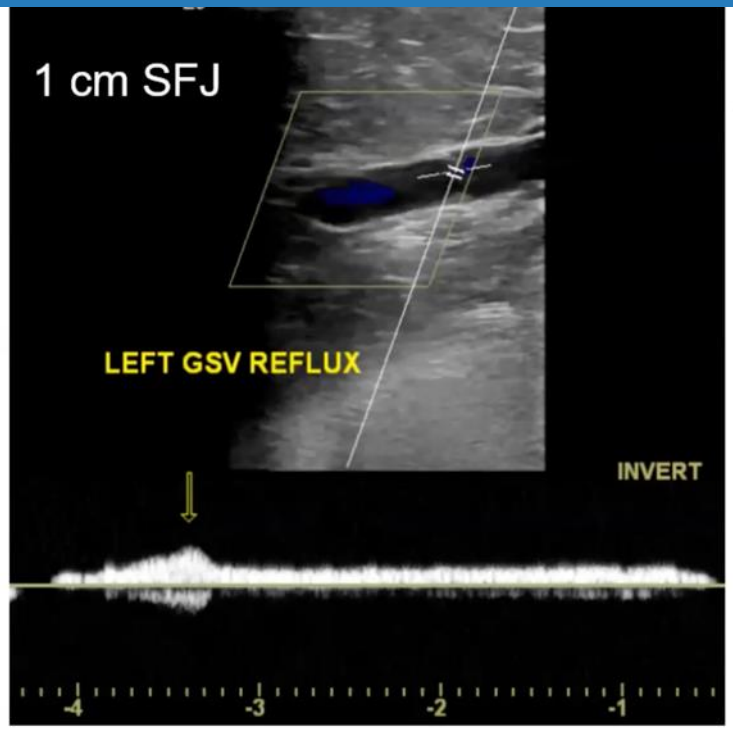
Laser

Sclerotherapy

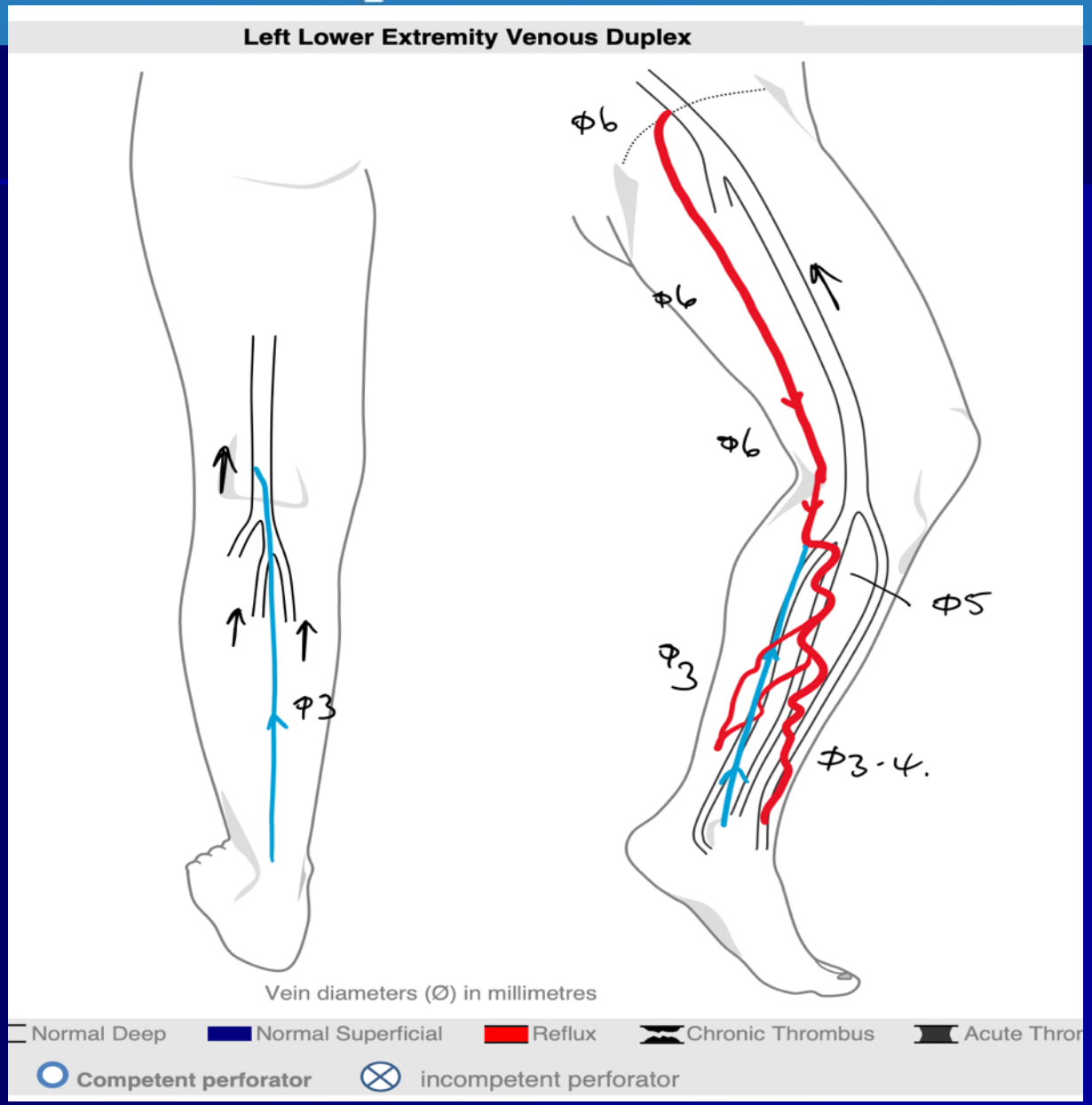
MechanoChemical Sclero

Vascular Assessment

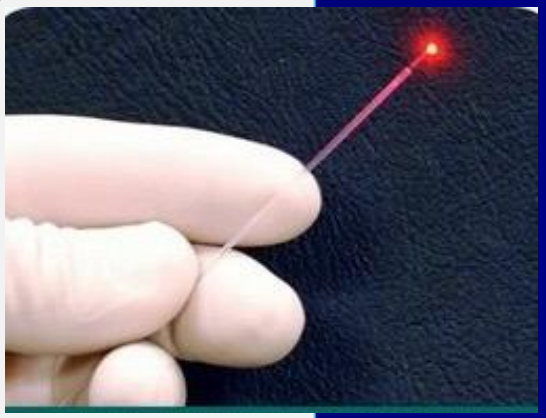
Venous Duplex Ultrasound



Venous Duplex Ultrasound



SUITABLE FOR ENDOVENOUS Rx (EVT)?

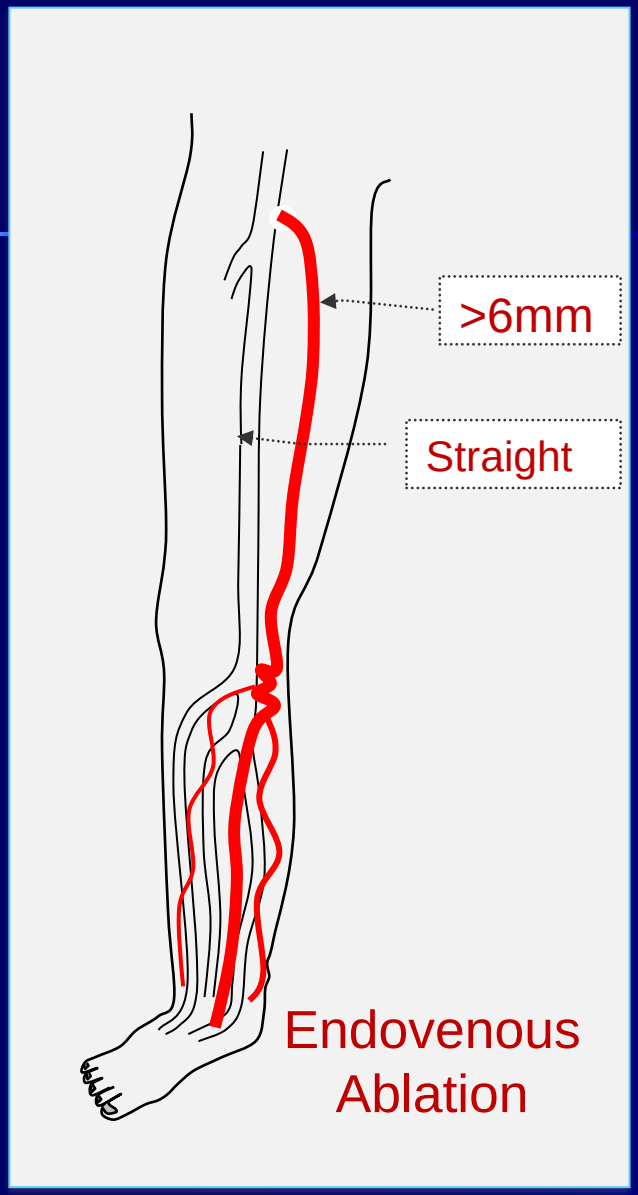


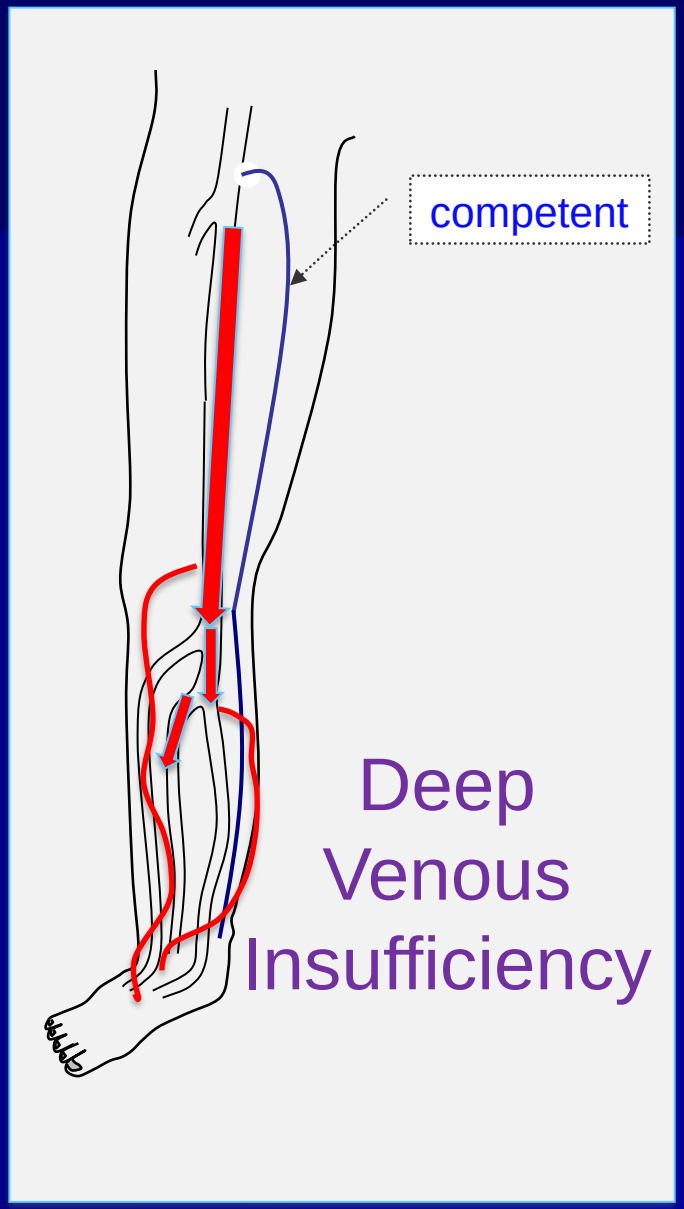
Endovenous Ablation

competent

Ultrasound Guided Sclerotherapy

SUITABLE FOR ENDOVENOUS Rx (EVT)?





PRACTICAL PRIORITIES

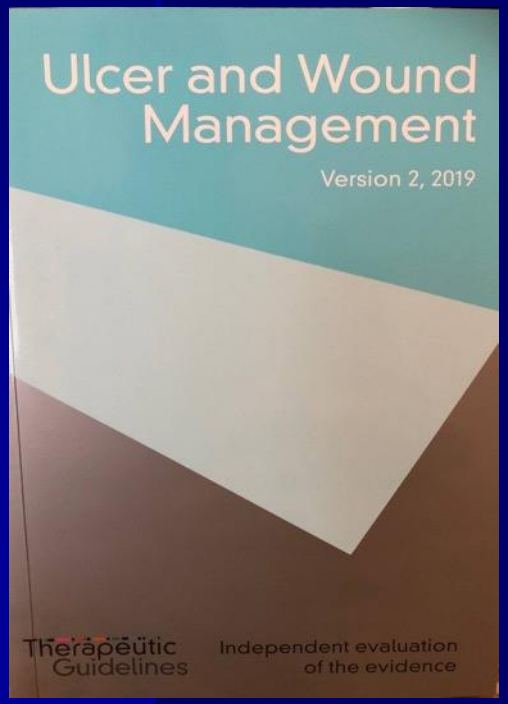
- Ensure Vascular Supply
- Drain Sepsis
- Treat Infection
- Determine Aetiology
- Debridement
- Granulation / Wound Contracture
- Epithelisation
- Prevention

Debridement

DEBRIDEMENT

To debride or not (bony prominences etc.)

Mechanism Surgical



Mechanical ultrasonic
suction
dressings

Chemical dressings

Autolytic



Locally Infected Wound or Heavy Wound Colonisation

“Versajet” or Ultrasonic debridement

ULTRASONIC DEBRIDEMENT

28/12/2001

31/12/2001

27/2/2002

18/3/2002

PRIORITIES

- Ensure Vascular Supply
- Drain Sepsis
- Treat Infection
- Determine Aetiology
- Debridement
- Granulation / Wound Contracture
- Epithelisation
- Prevention

Granulation / Wound Contracture

Healing

- Promote Granulation
  - Restore vascular supply
  - Reduce oedema
  - Remove Wound fluid
  - Restore oxygenation (possibly Hyperbaric therapy)

- Protect granulation

- Wound Contracture
  - Delayed primary closure
  - VAC dressing system

Wound closure / coverage

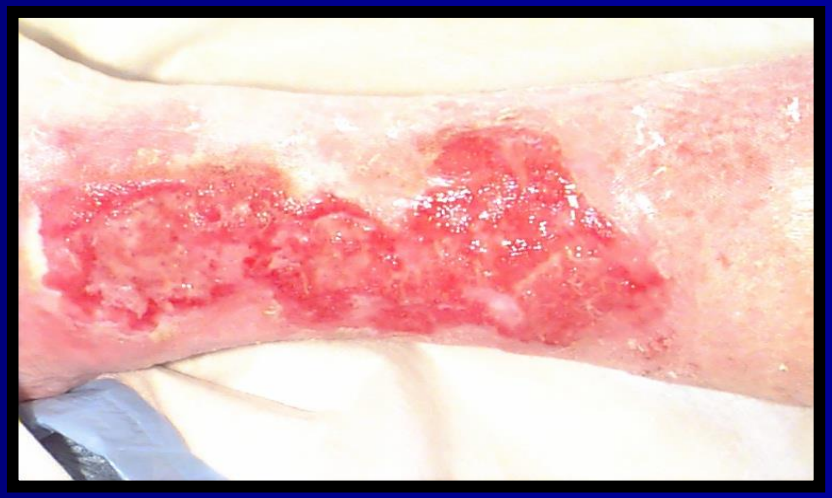
Plastic surgery Free flaps / local flaps

Wound Contraction
Negative pressure wound dressings / VAC dressings

WOUND EPITHELISATION

Granulation.

Epithelialisation.



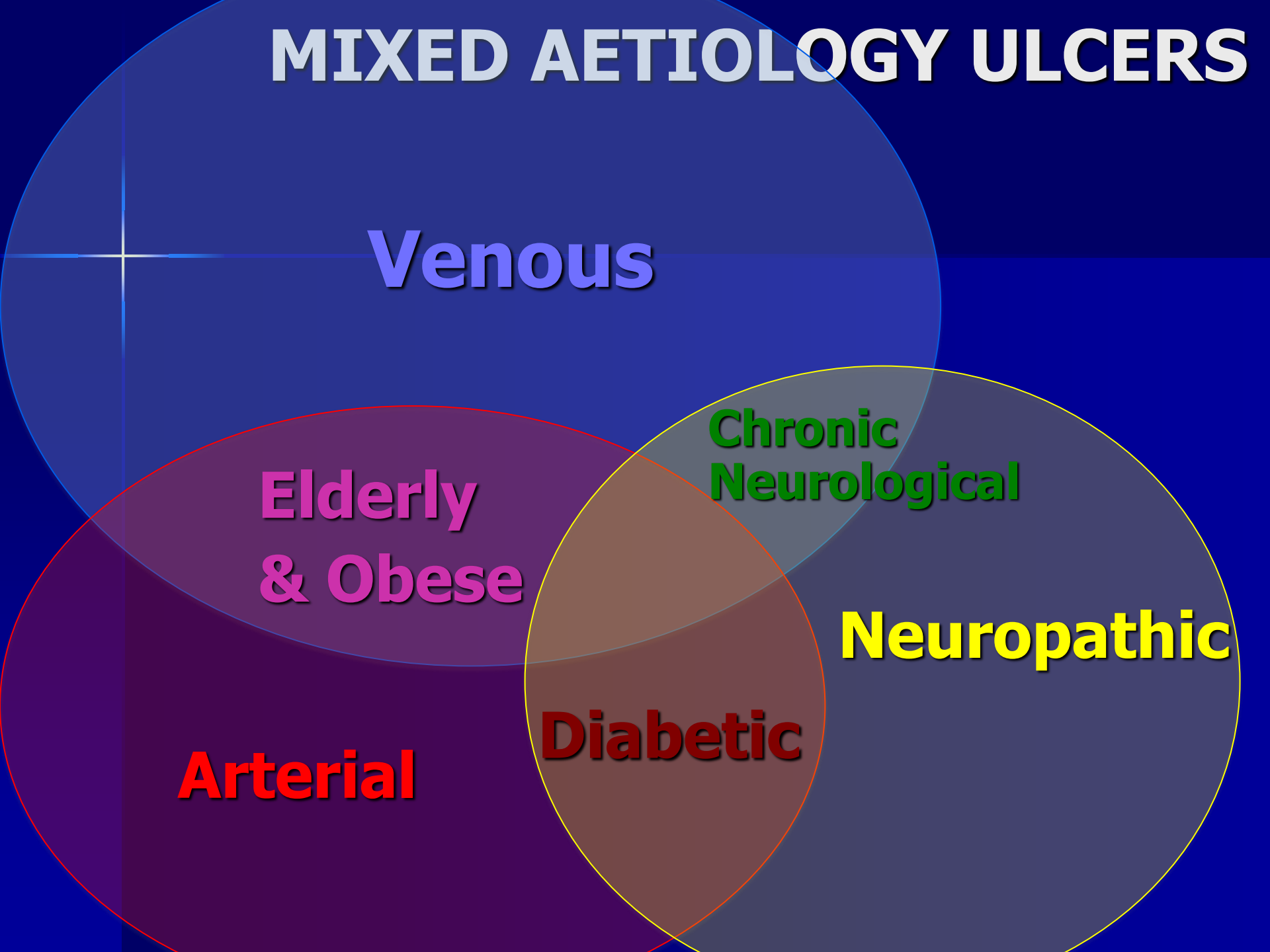
Epithelisation

- Vascular Supply
- Sepsis / Infection
  - Aetiology
  - Debridement
- Granulation / Wound Contracture
  - Epithelisation

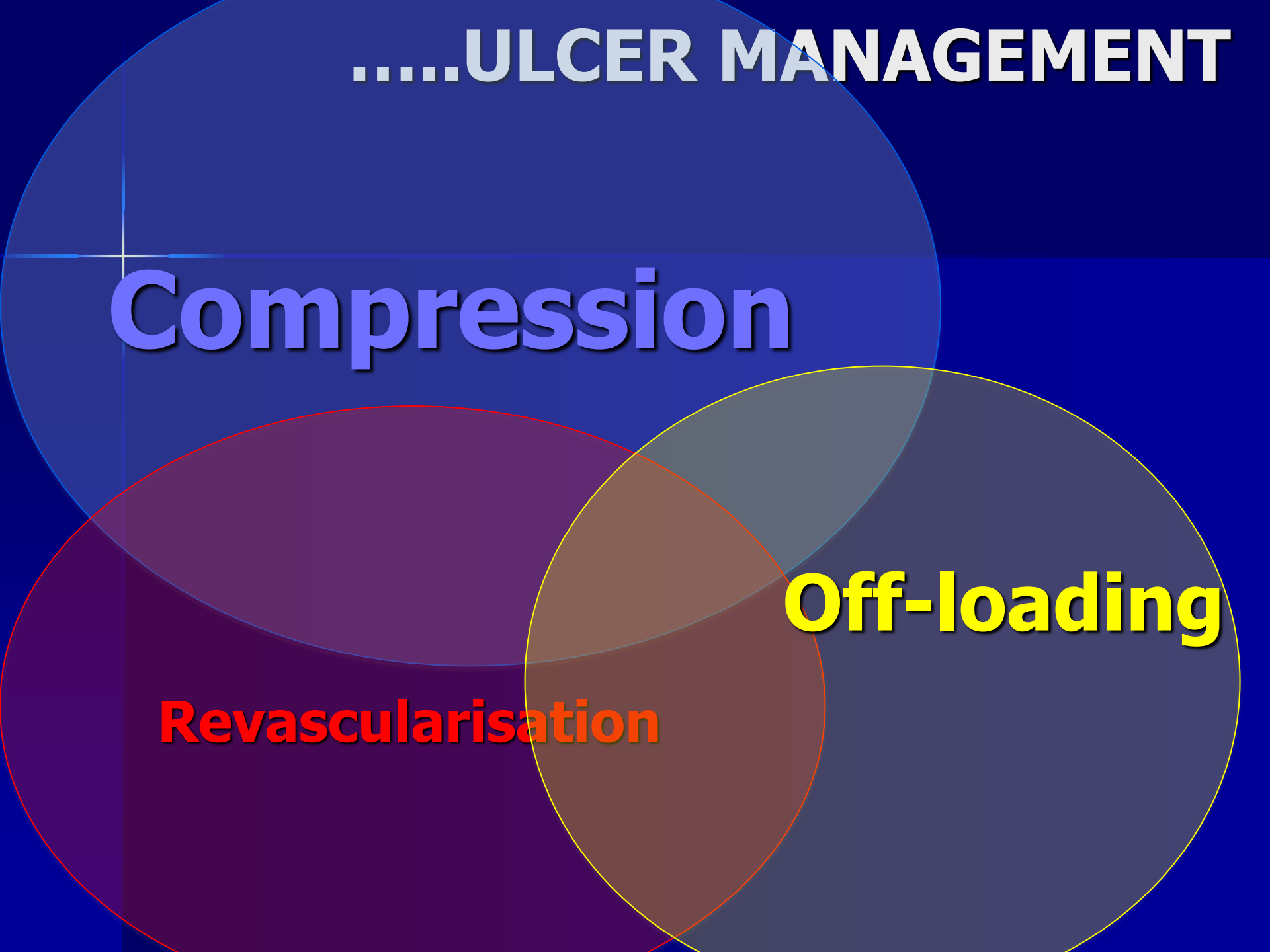
Pressure Offloading Splints, Orthotics, Casts

Pressure Offloading Splints, Orthotics, Casts

MIXED AETIOLOGY ULCERS



.....ULCER MANAGEMENT



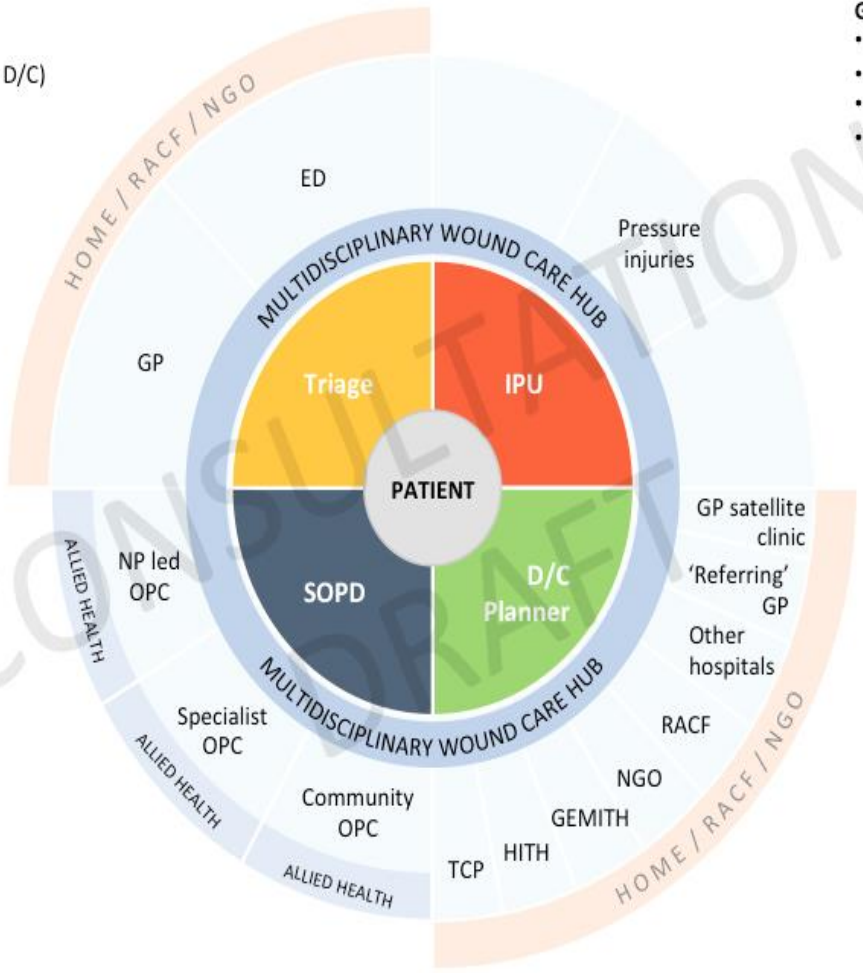
Complex wounds !
-Early recognition

- Chronicity
- Complexity
- Multi / mixed aetiology
- Pain & suffering
- Costs / delays / inefficiencies
- Escalating treatment strategies
  - VAC / Debridment/ Oxygen / Hyperbaric
  - Surgery resection & grafting
  - Lymphatic devices / Strategies

Multidisciplinary Care

Integrated Wound Care and Tissue Integrity Service framework

Wound Care Hub:
- Referral triage
- Wound care planning (incl. D/C)
- Specialist consultation
  - GP
  - IPU/SOPD
  - NGO/RACF
- Research/education



GCUH and Robina hospital
- Vascular
- Endocrinology
- Orthopaedic
- Plastics

Specialist OPC:
- Podiatry
- Vascular
- Orthopaedic
- Plastics