

# Ignoring lower limb oedema will lead to ineffective care

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It can't be good for me, and maybe I am becoming slightly obsessive, but the lack of attention paid to tissue oedema is really beginning to irritate. At conferences, for example, when infection or exudate management is discussed in relation to lower limb ulcers, I am struck how the obvious conclusions are so often missed. I find myself looking around to see if anyone else is going to pipe up and mention it.

Thankfully, from correspondence and discussion with colleagues, I know I am not alone and that others are also trying to state the obvious, which is simply this — that uncontrolled oedema is a major contributor to non-healing lower limb ulcers, whatever their aetiology.

The East London Wound Healing Centre receives referrals from around London and south-east England. We see many soggy, macerated and erosive legs and in our experience, what may have started as a small ulcer can rapidly deteriorate, despite the use of standard compression therapy. The state of their legs is ruining these patients' lives.

It seems to me that once compression therapy is used then nurses think that the box has been ticked and that whatever happens after will not be due to a lack of compression. Yet a limb full of oedema will produce a wet, dripping wound, often with maceration to the heel. This will produce pseudomonas conditions that are guaranteed to frighten the patient, relatives and nurses alike. Unfortunately, the response is too often to produce

the antibiotics, grab the nearest silver dressing or try a treatment that claims to offer greater absorption. None of these techniques are necessarily incorrect, but neither does any of them tackle the fundamental underlying cause — uncontrolled oedema.

Unfortunately, although many articles on compression therapy discuss Laplace's Law, in clinical practice nurses lack the courage or confidence to implement it. A larger limb needs greater compression, but when dealing with maceration, effective

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therapy needs to go hand-in-hand with effective pain relief. If a patient's GP is reluctant to provide opiates, then breaking this ineffective cycle will be difficult.

If we are to deal effectively with oedema, then we need to review the compression regimens that we offer. Standard therapy is good for standard ulceration — but where the leg shape or presence of oedema is more complex, we have to be more creative. Competent application of compression therapy is not simply about ticking the boxes. We need to establish whether the compression is actually doing its job and emptying the tissue of oedema.

The team at the East London Wound Healing Centre teaches both nurses and patients to look for guttering on the

limb because this is an objective sign that oedema is reducing with the compression therapy; if this is not observed, the compression will not be adequate, however nicely applied and thus will not impact on exudate reduction or control the infection. As long as it is tolerated, the compression therapy, or the sub-bandage pressures, are increased until we see a therapeutic effect.

One really difficult group to treat is those patients with dripping, oedematous legs which are incompressible or who have an ankle brachial pressure index (ABPI) of around 0.5. When a patient does not have other ischaemic symptoms, and with specialist support, surely compression has a role? Yet through conversations with colleagues at conferences or in connection with tertiary referrals, it appears that many healthcare professionals believe compression therapy of any kind is far too risky and flies in the face of clinical guidelines that often advocate compression if the ABPI is >0.6. However, when it is obviously detrimental to do nothing, I would suggest that the risks and benefits of applying a light 3A compression should be assessed in the same way as numerous other specialist medical treatments. There may be some risks involved, but are they great enough to outweigh the real benefits of compression therapy?

In the final analysis, it is vital that healthcare professionals should at least try to address patients' oedema by evaluating their skin tolerance, using their knowledge of compression theory and thus providing the patient with a fighting chance of improving their quality of life and avoiding the misery that oedema can bring. **WUK**