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Lower Limb Pathway

Patient Presentation

Patient presents with lower limb wound and/or oedema.

Lower Limb Assessment

Follow and complete the leg ulcer (LU) assessment chart:

Immediate care:

- Clean wound with appropriate solution;
- Debride – according to scope of practice;
- Wound swab - only if suspected or spreading infection (follow the Scottish Ropper Ladder)
- Holistic wound assessment & management (9SWAT);
- Skin care before applying bandage, hosiery or garment.

Skin Care:

- Carry out basic lower limb skin care on every patient.
- Either wash in the shower or use a basin with a clean, disposable liner.
- Cleanse with a bland non-perfumed soap substitute or emollient.
- Gentle removal of dry skin, plaques and wound slough and debris may require a debridement
- Include hyperlink to debridement pathway.
- Dry fully then apply an appropriate moisturiser to the whole leg and allow to absorb prior to application of dressings.

In the presence of a Skin Tear:

- Follow Skin Tear Management Pathway.
- If not healed after 2 weeks, follow LU assessment chart and complete the lower limb assessment, including ABPI.

ABPI

ABPI interpretation:

ABPI > 1.3 – consider possibility of calcification and possible need for specialist advice.

ABPI 0.8-1.3 – patient requires compression therapy 20-40mmHg. See hosiery guide (under review)

ABPI< 0.8 – **Routine** referral to Vascular Team

ABPI < 0.5 – **Urgent** referral to Vascular Team if vascular compromise has been diagnosed. Please consider other cause of oedema such as heart failure, lymphoedema and refer to appropriate team.

Red Flags

Does patient have any of the following?

- Acute wound infection, with spreading infection
- Symptoms of sepsis
- Suspected acute DVT - throbbing pain in 1 leg (rarely both legs); swelling in 1 leg; warm to touch; red or darkened skin around the painful area (take into consideration darkened skin tones); punched out veins that can be painful to touch).
  - DVT Flowchart – ARI ED
  - DVT – Lower Limb – DGH ED

Yes → **Refer**

Follow local guidance for the condition.
Do not start compression.

No

Red Flags

Does the patient present with the following?

- Red, hot swollen foot - Charcot Neuro-osteoarthropathy
- Acute foot ulceration (with or without Diabetes)
- Spreading infection in the foot.

Yes → **Refer**

Consider Urgent referral to Diabetes MDT or Podiatry Service.

Podiatry In-patient Referral Process

Podiatry Outpatient Referral Process

No

Red Flags

Does patient have any of the following?

- Bleeding varicose veins
- Acute or suspected critical limb ischaemia- Consider: pallor, pain, paresthesia, paralysis, pulselessness, and poikilothermia (Cold or reduced temperature in affected lower limb)

Yes → **Refer**

Refer to Vascular.
Do not start compression.

No

Red Flags

Does patient have the following?

- Suspected skin cancer

Yes → **Refer**

Refer to Dermatology or Plastics through the Urgent Suspected Skin Cancer route.

No

No Red Flags

Consider starting reduced compression = 20mmHg (hosiery guide (under review).
Use 2 reduced compression liners each 10mmHg
See page 2

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