

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.

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

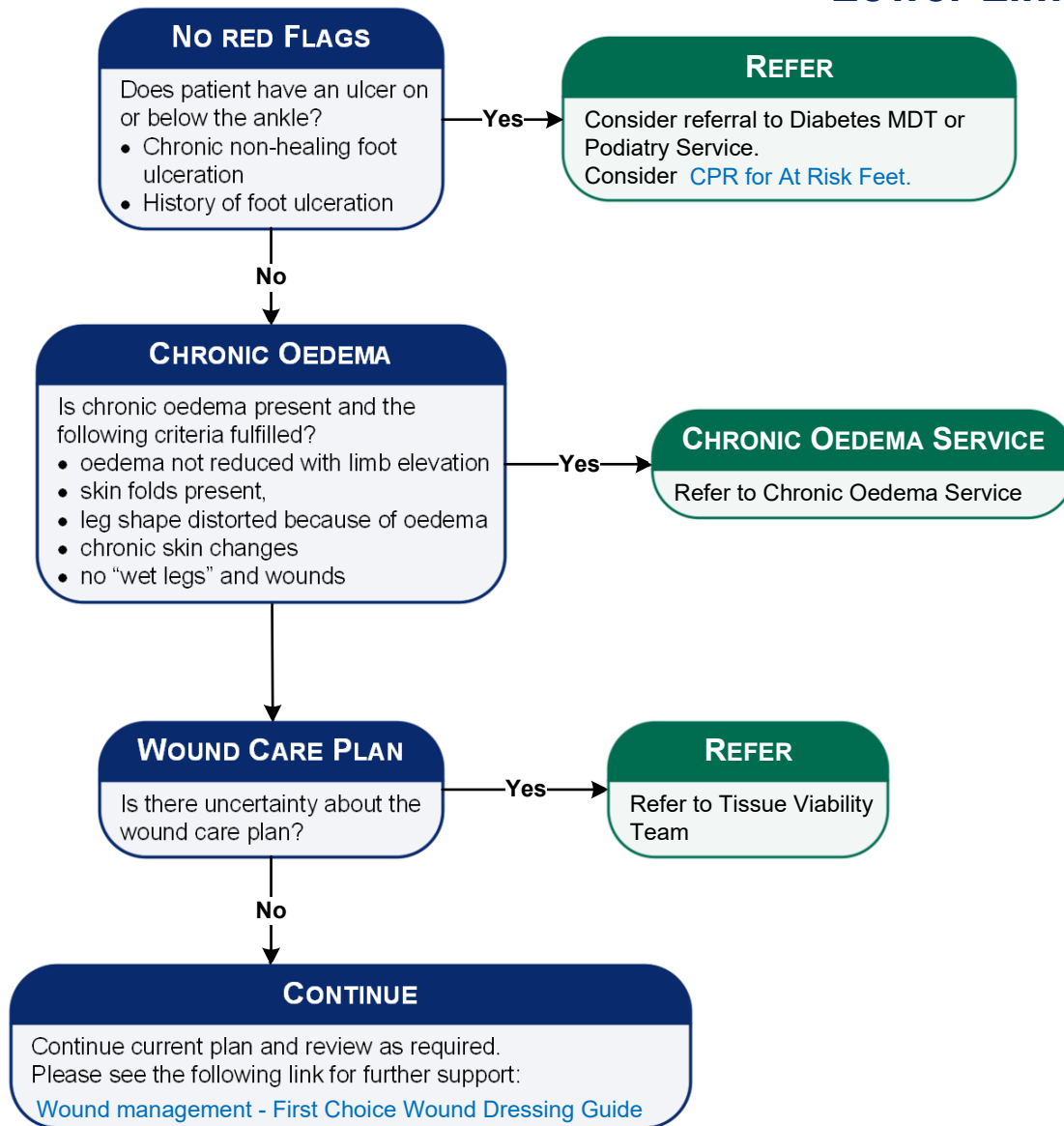
Consider starting reduced compression = 20mmHg (hosiery guide under review)
Use two 10mmHg compression liners or one 20mmHg compression liner stocking
See [page 2](#)

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.
- 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.

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Version – 2.0	Title – Lower Limb Pathway	Department – Tissue Viability Service	FINAL
Creator – Tissue Viability Team	Lead – Ines Pereira	Last Review – 09 June 2026	Next Review – 09 June 2028