

Venous leg ulcers: Summary of new clinical practice guidelines published August 2014 in the Journal of Vascular Surgery

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The Society for Vascular Surgery® (SVS) and the American Venous Forum (AVF) published guidelines for the management of venous leg ulcers in August 2014. The goal of this article (Part 2) is to summarize the guidelines that address diagnosis and treatment recommendations published jointly by the SVS and AVF that may affect the nursing practice of vascular nurses. Specific sections include wound evaluation, therapies used on the wound bed itself, compression, and operative or endovascular management. Part 1, published elsewhere in this issue, addressed the epidemiology and financial impact of ulcers, venous anatomy, pathophysiology of venous leg ulcer development, clinical manifestations, and prevention of venous leg ulcers. These 2 parts together provide a comprehensive summary of the joint SVS and AVF guidelines for care of venous leg ulcers. (J Vasc Nurs 2015;33:60-67)

PURPOSE

The Society for Vascular Surgery® (SVS) and the American Venous Forum (AVF) published guidelines jointly for the management of venous leg ulcers in August 2014.¹ The goal of this article is to summarize the guidelines that address diagnosis and treatment recommendations published jointly by the SVS and the AVF that may affect the nursing practice of vascular nurses. A companion article in this issue, “Venous leg ulcers: Impact and dysfunction of the venous system” addresses the epidemiology and financial impact of venous ulcers, anatomy and pathophysiology of venous leg ulcer development, clinical manifestations, and prevention of venous leg ulcers. The companion article is designed to be read first to familiarize vascular nurses with the issues in the venous system to better understand the basis for diagnosis and treatment of venous leg ulcers.

The venous leg ulcer guideline committee included members from both the SVS and AVF and was further divided into 6 subcommittees to address diagnosis, compression issues, endovascular and surgical interventions, general wound care, ancillary treatments, and preventative care. Each subcommittee was charged with evaluating the evidence available for quality and strength. The grading of recommendation assessment, develop-

ment, and evaluation (GRADE) system used by the American College of Chest Physicians provided a way to evaluate all the studies related to venous topics that had been published in a peer-reviewed journal in any language.¹ High-quality evidence from randomized, controlled trials received an A, whereas moderate quality evidence from RCTs received a B, and lesser evidence from observation or case studies received a C. Strong recommendations were assigned a 1, indicating greater benefit than harm from the practice. When weak evidence of benefit or little difference in risk was found, a suggestion rather than recommendation was assigned with a 2. Best practice is recommended when no research evidence is available or there is no alternative to that practice which must be provided. The GRADE scale then includes 1A, 1B, 1C, 2A, 2B, 2C, and best practice.

WOUND EVALUATION

Best practice is used as the evidence for clinical evaluation of the leg by a specialist in vascular care. The vascular specialist is to examine the leg for signs of venous ulcers and the cause of these ulcers, and to provide specific documentation of the size and location of any venous ulcer location. Outcome measures after interventions, either beneficial or complications, need to be documented well to show the impact on venous leg ulcers as a best practice also. “Recommend that all patients with venous leg ulcer be classified on the basis of venous disease classification assessment, including clinical CEAP, revised Venous Clinical Severity Score, and venous disease-specific quality of life assessment” is also a best practice.¹

The classification tools are known to nurses who specialize in venous issues, but these scoring systems may be less well known by other vascular nurses, so each will be explained briefly. CEAP stands for Clinical, Etiologic, Anatomic, and Pathophysiologic classifications. The CEAP measure developed in 1994 and revised in 2004 is a static scale that is used extensively in clinical and research settings to establish a baseline for venous disease.^{1,2} The basic CEAP (Table 1) is a less extensive version of the tool

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TABLE 1

BASIC REVISED CLINICAL, ETIOLOGIC, ANATOMIC, AND PATHOPHYSIOLOGIC (CEAP) CLASSIFICATION SYSTEM

<i>CEAP</i>	<i>Definition</i>
Clinical classification	
C0	No visible or palpable signs of venous disease
C1	Telangiectases or reticular veins
C2	Varicose veins
C3	Edema
C4a	Pigmentation and/or eczema
C4b	Lipodermatosclerosis and/or atrophie blanche
C5	Healed venous ulcer
C6	Active venous ulcer
CS	Symptoms, including ache, pain, tightness, skin irritation, heaviness, muscle cramps, as well as other complaints attributable to venous dysfunction
CA	Asymptomatic
Etiologic classification	
Ec	Congenital
Ep	Primary
Es	Secondary (post thrombotic)
En	No venous etiology identified
Anatomic classification	
As	Superficial veins
Ap	Perforator veins
Ad	Deep veins
An	No venous location identified
Pathophysiologic classification (basic)	
Pr	Reflux
Po	Obstruction
Pr,o	Reflux and obstruction
<u>Pn</u>	No venous pathophysiology identifiable

Modified from Eklöf B, Rutherford RB, Bergan JJ, et al. Revision of the CEAP classification for chronic venous disorders: consensus statement. *J Vasc Surg* 2004; 40:1248-52 with permission from Elsevier.

and more appropriate for clinical use.² The clinical classification of an active ulcer as C6 or CEAP-6 and a healed ulcer as C5 or CEAP-5 are the designations most applicable to these guidelines, although C4b indicates changes that may lead to venous ulcers and some later guidelines address this also.

The Venous Clinical Severity Score (VCSS) was published in 2000 and revised in 2010 to provide a measure sensitive to changes in venous disease following treatment (Table 2).³ The assessments with this tool document initial status followed by measurements at intervals to show change after different treat-

ment options.⁴ The original and revised VCSS have been shown to be valid and reliable with the same and different observers over time. A VCSS score may range from 0 to 30, but a score of >8 should alert the nurse to observe closely for progression of the current venous problem.^{1,5}

Post-thrombotic syndrome may be associated with venous ulcers in patients who have had deep vein thrombosis. Several scales are available, but the guidelines recommend the use of the Villalta score⁶ (Table 3⁷) with the CEAP for the most accurate diagnosis of post-thrombotic syndrome, especially with a C5 or C6.¹ Mild post-thrombotic syndrome has a score of 5-9, moderate is 10-15, and severe is >15 points or the presence of a C6 ulcer.⁷ Disease-specific quality of life measures are recommended, but no specific tool is named in the guidelines.¹

Strong recommendations are available for some diagnostic procedures. All patients with suspected venous ulceration are strongly recommended (grade 1B) to undergo venous duplex ultrasonography of the entire venous system, an ankle-brachial index measurement and (grade 1C) wound biopsies if the wound has not healed after 4-6 weeks of treatment.

Suggestions for diagnostics include (grade 2B) venous plethysmography when ultrasonography has been inconclusive, and (grade 2C) laboratory testing for thrombophilia when venous ulcers recur chronically or a history exists of recurrent thrombosis and against routine culture of wounds that do not show specific signs of infection. A grade 2C suggestion to only do extensive other testing when iliac vein obstruction is suspected or surgical interventions are planned, so the diagnostics are a necessity is a cost-saving measure. Cost savings is a consideration in the suggestions made where the benefit-risk balance is equal.

WOUND THERAPY

Many direct wound therapies are available for management of venous leg ulcers. This section addresses the wound bed, infection control, primary dressings, and adjuvant therapy. The underlying venous hypertension must be controlled for these measures to work, so each is used concurrently with compression or other venous interventions that will be addressed elsewhere.¹

Wound bed

Cleansers and debridement are the main ways of preparing the wound bed, but neither is effective without good nutrition and careful documentation at each dressing change.¹ Nurses may be the ones doing these dressing changes, so remembering to measure height, width, and depth and documenting those on a regular basis is necessary. Cleansing the wound with a nonirritating solution with minimal trauma from chemical or mechanical sources initially and during each dressing change is suggested (grade 2C). Debridement during the initial evaluation is recommended (grade 1B) to remove the burden of necrotic tissue, excess bacteria, and nonviable cells. Further debridement is suggested (grade 2B) on a maintenance basis to improve appearance and ability of the wound to heal, although the method of debridement is left to the provider's choice.¹

Several methods of debridement are used with varying recommendation. A strong recommendation (grade 1B) for the use of local or stronger anesthesia was given for surgical debridement. The use of eutectic mixture of local anesthetics cream was

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