



The importance of early intervention in the management of chronic oedema in the community

Clare Wilson BSC (Hons), Dip.HE, RGN, Current position: Tissue Viability Support Nurse, University Hospital North Staffordshire
At the time of writing this poster Tissue Viability at Birmingham Community Healthcare Trust



1. Lymphoedema



2. Previous bandage damage anterior left ankle due to inadequate padding and shaping of the limb



3. Lymphovenous ulceration, posterior calf

Case study

An 81 year old male with a history of diabetes (type 2), hypertension and recent reduced mobility and dependency oedema exacerbated by diabetic neuropathy to feet. Patient was referred to tissue viability service for chronic lymphovenous ulcers and also presented with non-pitting oedema and positive Stemmers sign.

He was previously in a 2-layer compression bandaging system; toe bandaging was stopped and resulted in disproportionate oedema to dorsum and toes. Oedema has been resolved with cohesive short stretch bandage system*.

Background

East and North Birmingham (formally BEN PCT) has a population of around 404,500, with 29% being 50 years old or over.

On average 81.5% of patients seen by district nurse teams in the PCT have chronic oedema of some degree.

Methods

An audit was carried out of district nurse teams in two areas of North Birmingham.

The audit looked at all types of visits to patients' homes over a one week period.

The reason for visiting in the majority of cases was for treatment of leg ulcers. Chronic oedema management was not a reason, rather an umbrella term for several reasons for a nurse visit. This demonstrates the "knock on" effect of oedema onto other issues, i.e. venous leg ulcers.

Results

Major themes from the audit include;

- The length of time patients are treated - over 88% of patients reported having oedema for 6 months or longer
- The percentage of those receiving no treatment
- Hospital admissions related to oedema
- Staff training

Of note was a majority of patients receiving no treatment for chronic oedema, and those whose treatment may not be suitable.

Key to managing chronic oedema effectively is early identification, bandage competency and confidence in hosiery measurement and selection. However, there are issues with staff confidence in managing chronic oedema and the majority of nurses rated their confidence as 2-5, on a scale from 1-10 (1 being least confident, 10 being very confident). They reported having had no training in the management of chronic oedema in the last 12 months, despite feeling they would like to have training.

Conclusions

It is estimated that 60-80% of all leg ulcers are a result of chronic venous disease (SIGN, 2010). Chronic oedema also impairs venous ulcer healing (Anderson, 2012) and causes a number of physical and psychological effects to the patient (Keeley, 2008).

There is also an increased risk of cellulitis and in the author's PCT in 2010/2011 there were a total of 982 inpatient episodes of cellulitis as a primary diagnosis into hospitals, with a further 785 inpatient episodes with cellulitis as a secondary diagnosis. The total cost for the Strategic Health Authority was £2,990,392.00. The use of appropriate treatment has an impact on the nurse hours spent treating them for complications, as well as costs of inappropriate bandage systems and hospital stays for cellulitis.

References

Anderson, I (2012), Early intervention for patients with chronic venous insufficiency. Wounds UK 8 (1):20-22

Keeley, V (2008) in Skills for Practice: Management of chronic oedema in the community, Wounds UK, Aberdeen, 2009

SIGN (2010), Management of chronic venous leg ulcers: A National Clinical Guideline, Scottish Intercollegiate Guidelines Network, 26: 1-29

* Actico® - Activa Healthcare