

# Treatment of a patient with painful vasculitic ulcers due to systemic lupus erythematosus

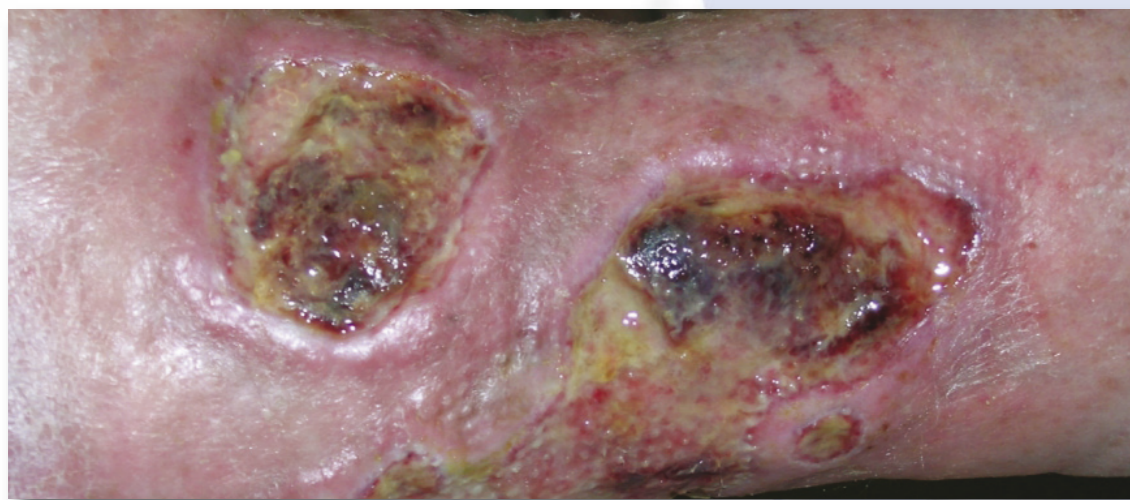
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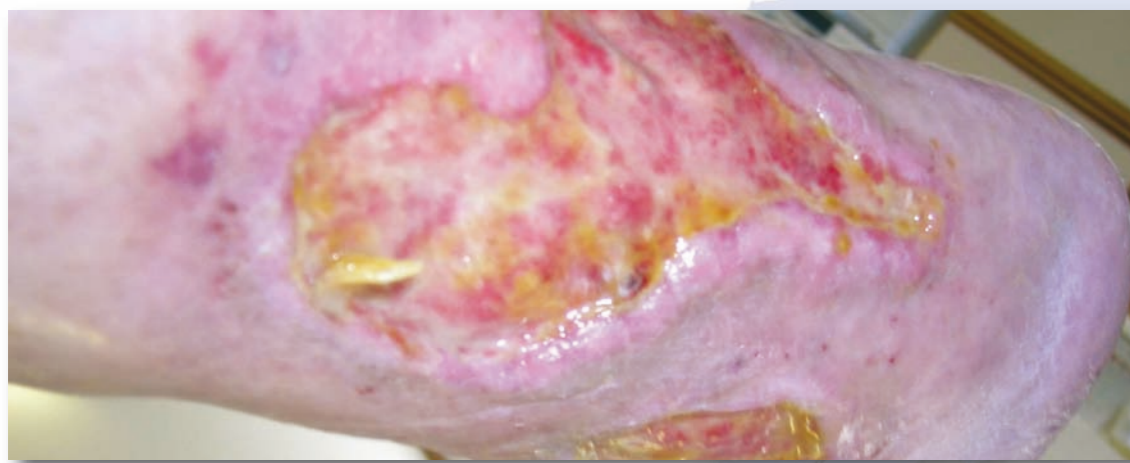
Left outer calf on admission 04.04.2007 Pain score: 10



Right inner calf on admission 04.04.2007



Necrotic and sloughy tissue present



Livedoreticularis (net-like appearance - characteristic of SLE)

## Introduction

Lupus is a condition of chronic inflammation and is one of the many auto-immune diseases where the immune system turns against parts of the body it was designed to protect. Systemic lupus erythematosus can affect many parts of the body including the joints, skin, kidneys, heart, lungs, blood vessels and brain. (Leach 1998) Although people with the disease may have many different symptoms some of the most common ones include: extreme fatigue, joint pains and skin rashes which are made worse by exposure to strong sunlight. In this case study a 62 year old lady with a long history of Sjorgen's syndrome and SLE developed a small vessel vasculitis in June 2006, followed by substantial painful ulceration around both ankles.

## Case Study

This lady was referred to the nurse-led community leg ulcer clinic in April 2007, by which time the Rheumatologist was managing her care with input from a Dermatologist and Nephrologist. The aim of her treatment was to suppress the immune system by fortnightly pulses of intravenous cyclophosphamide and oral steroids. To protect her from the side effects of steroids causing possible osteoporosis she was prescribed biphosphonates, but found the extreme nausea caused by the cyclophosphamide to be the most debilitating of the side effects, despite anti-emetics. To avoid the development of cellulitis the Dermatologist had recommended the use of prophylactic antibiotics. She described her pain as a continual throbbing scoring 10/10 and was distressed by dressing changes, requiring oxycodone 5mgs prior to her visits in addition to modified release oxycodone 80mg twice daily with a top-up dose at midday. The ulcers were large, discrete, punched-out and wet with some slight covering of yellow slough. The peri-wound skin was inflamed and very sensitive to touch. The ulcers had previously been dressed three times a week with a honey dressing and then a hydrocolloid/hydrofibre which was not wet enough to gel and therefore caused more pain during removal.

Guided by the Best Practice Statement in Minimising Trauma and Pain in Wound Management (2004) the patient required a dressing which would not adhere to the wound bed, manage the exudate, lift the slough gently and protect the peri-wound area from trauma. Compression therapy is contra-indicated in this vasculitic ischaemic type of ulceration which can be extremely painful. (Armitage, Roberts 2004)

## Method

After careful consideration and with informed patient consent (NMC,2004) ActiFormCool® hydrogel sheets were selected as the most suitable dressing to manage her wound pain. Dressings were performed three times a week, leaving the film backing in place so that the ulcers remained moist and dressings easy to remove. A simple emollient of 50/50 white soft paraffin and liquid paraffin was applied gently to the peri-wound skin after washing. The dressings were retained in place with a light bandage. Evaluation was undertaken at each visit to assess healing and progress was monitored by monthly photography.

## Discussion

The dressing was quick and easy to apply and the patient found it soothing and comfortable. She no longer dreaded the dressing changes and was able to discontinue analgesia prior to visits. Her pain score decreased to 3-4 out of 10 and she felt her ulcers were no longer impacting on her quality of life, evidenced by her pleasure at being able to resume driving. Rapid progress was made with the healing process in conjunction with the treatment of her disease and the choice of dressing clearly contributed to her well being.

## Conclusion

Some wounds are difficult to manage due to underlying pathology and this was one such case. ActiFormCool® provided an optimum wound healing environment with pain reduction apparent from the first application, leading to a steady progression towards complete healing.

## References

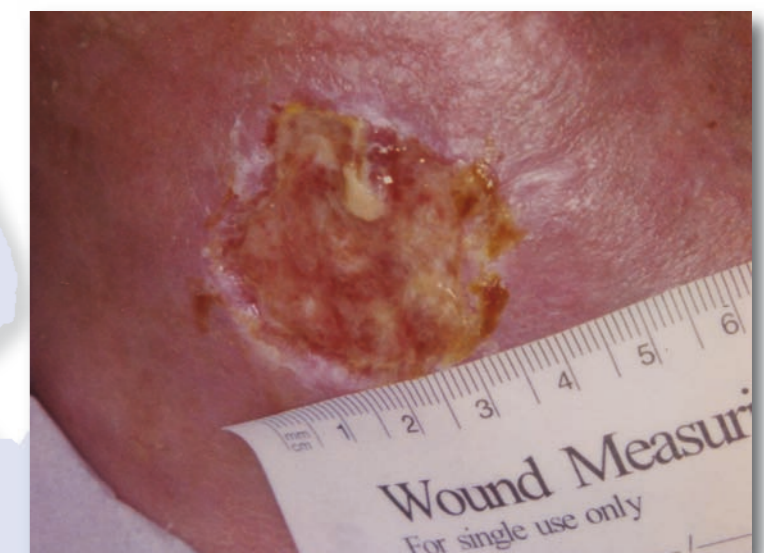
Independent Advisory Group (2004) Best Practice Statement: Minimising Trauma and Pain in Wound Management. Wounds-UK Publishing, Aberdeen. Nursing and Midwifery Council (2004) The NMC Code of professional conduct, Standards for Conduct, Performance and Ethics. NMC, London. Armitage M, Roberts J (2004) Caring for patients with leg ulcers and an underlying vasculitic condition. BJCN Wound Care Suppl. 9 (12) : S16-22. Leach M (1998) Signs and symptoms of systemic lupus erythematosus. Nursing Times 94 (13) : 50-52



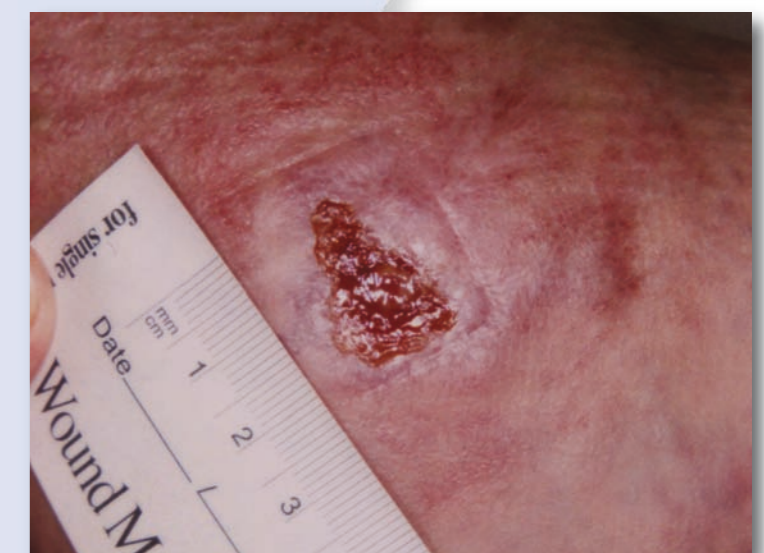
Left outer 31.08.2007 Pain score: 3-4



Right inner 31.08.2007



Left medial malleolus 10.04.2007



Left medial malleolus 05.06.2007