

The Leg Ulcer Forum Journal

Issue 14 Spring 2001



President: Prof.C.Moffatt



Conference Report
Malodorous Wounds
Complementary Therapies
Body-Image and Self-Esteem
Leg Ulceration from a Patient's Perspective

Contents

Editorial	3
Chairperson's report – a Positive Start!	4
New Members of the LUF Executive	5
Conference Report – December 2000	6
Living With Leg Ulcers – a Patient's Perspective	7
The Views of Non-compliant Patients	11
Malodorous Wounds	12
Body Image and Self Esteem	15
Complementary Therapies	18
Psycho-social effects of Leg Ulceration	20
Joining the Leg Ulcer Forum (form)	21
Guidelines for submitting articles for publication in the LUF Journal	22
Courses	23
Conferences	23

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LEG ULCER FORUM

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Editorial

Dear Readers

A very warm welcome in particular to the new members of the leg ulcer forum.

It was good to meet so many of you at the December conference, which I must say was a great success. A number of you approached me at the conference and expressed a wish to voice their views on clinical practice. I'm sure there are lots of innovative activities going on which our readers would like to hear about, so do not despair – put pen to paper, we would love to hear from you.

This latest 'bumper' edition of the journal encompasses the themes of our December conference *Could you Live with a Leg Ulcer?* Much of the work performed in relation to leg ulceration has focused on a biomedical approach; the aim of this conference was to focus on *the patient*. Indeed, this proved to be a very popular theme, which was demonstrated through the number of delegates attending the conference: it was very unfortunate that we had to turn away late comers. So beware – book early to secure a seat at our conferences later in the year (details are on page 23).

As part of the Executive Committee I can assure you we are growing in strength (see the Chairman's report on the next page for an update of our activities). It is with deep regret that Linda Herbert resigned her position as Educational Facilitator earlier this year. Linda was a great asset to the forum executive and will be truly missed.

Hope to meet you in the later part of the year.

Best Wishes

A handwritten signature in black ink that reads "Lynfa M. Edwards". The signature is written in a cursive, flowing style.

Lynfa M Edwards, Editor

Chairperson's report – *A Positive Start!*

The Conference last December demonstrated to all who attended how far the Leg Ulcer Forum has progressed within the last twelve months. An enthusiastic and full audience – the conference was oversubscribed for the first time in a few years – verbalised many positive ideas that I am pleased to report the Executive Committee has been able to action already.

For a full conference report and an update on the current executive members, see pages 5 and 6. Welcome to Irene Anderson – co-opted onto the executive in January for her additional educational and organisational qualities.

In the light of feedback from yourselves, I am now pleased to be able to confirm that the Leg Ulcer Forum has a central contact point, via our Administrator. Please note that all correspondence should be sent to:

PO Box 337
Hartford
Huntingdon
PE29 1FX

whilst telephone messages can be left on the Leg Ulcer Message Line 01480 456798. This should not be used for direct patient advice, nor to speak directly to an Executive Member other than the Administrator. However, messages can be left for individual Executive Committee members and these will be forwarded on at the earliest opportunity.

In addition, the Leg Ulcer Forum now owns its own web address which is www.legulcerforum.com. Watch this space for our e-mail address!

Currently the membership of the Leg Ulcer Forum is over 1,000 following a successful mailshot at the beginning of the year. However, please note that this year renewal notices will go out in December for your attention.

Other diary dates to note are Friday November 23, 2001 (Sheffield) and November 30, 2001 (London), as these are when the Annual Conference will take place. Yes that's right, it will be the same programme but this year at two venues and will include slots for you to present 'free' papers. Put your thinking caps on now!

Exciting times are ahead for the Leg Ulcer Forum. We really want you to feel involved and be able to contact/share with us your clinical experiences and with a wider audience through either our Conference, the Educational Leaflets and/or the Forum Brochure. I hope you will agree we have made a positive start to the new millennium.

Finally, I would like to acknowledge and thank all the hard work that Rene White (Administrator, CRICP) has put in giving the Leg Ulcer Forum such a solid administrative foundation on which to build, and congratulate Caroline Dowsett on her recent appointment as Nurse Consultant – Tissue Viability.

I look forward to hearing from you in the not too distant future.

Yours sincerely



Mark Collier
Chairperson



Did you know?

In 1777, Benjamin Ben advised that healing of an ulcer would be safer if a wound on the other leg was created. He believed that ulcers caused varicose veins!

New members of the *LUF Executive*



Caroline Dowsett

MSc (Advanced Nursing Practice),
BSc (Hons), DN, RGN

Nurse Consultant Tissue Viability,
Newham Community Services NHS
Trust, London.

I have recently taken up the role of
Nurse Consultant in Tissue Viability,
having worked as a clinical nurse

specialist in the field for the past five years. Prior to this I
undertook a project to set up nurse-led leg ulcer services in the
community. My background is in vascular surgical nursing and
district nursing. My new role involves the provision of expert
clinical practice for patients with tissue viability needs, research
education and professional development.

Recently I have developed wound management guidelines and a
formulary package to cover the community, primary care and
acute trust. I lecture on tissue viability at City University and at
South Bank University, London.

I was successful in winning the Wound Care Nurse of the Year
Award in 1997 (Professional Nurse) and in 1999 (Nursing
Standard). I have published articles on wound management in a
variety of journals.



Brenda King

BSc, (Hons), RGN, DN, ONC.

Tissue Viability Nurse
Community Health, Sheffield

After qualifying as an RGN, I worked
in primary care and gained my District
Nurse qualification. In 1992 I was
appointed Tissue Viability Nurse for
the Sheffield community and have

been actively involved in the development of services locally
for patients with acute and chronic wounds. I am also involved
in developing prevention strategies for those people at risk of
compromised skin integrity.

My involvement with the leg ulcer service has included the
development and management of nurse led clinics, educational
programmes and involvement in writing the curriculum and
teaching on the ENBn18 within Sheffield University. In 1994 I
conducted a district-wide audit of leg ulcers, and following this
a multidisciplinary team developed local guidelines, which were
circulated in 1997. These have since been audited and are now
under review. My role also involves pressure prevention and

management providing clinical advice, educational programmes
and co-ordination of specialist pressure relieving equipment
across the city.

Following the achievement of a first class BSc honours degree
in health care research, I am now in the second year of a Master
in Advanced Nursing Practice, the topic of my dissertation is the
post operative management of the toe nail bed following toe
nail avulsion.

I am currently involved in a clinical research project which is
investigating the discolouration of granulation tissue in the
presence of anaerobic bacteria.

Having undertaken the ENBN18 at Charring Cross in 1993 and
a been a member of the LUF since it was founded, it gives me
great pleasure to be able to serve on the executive committee.



Victoria Quioc

MSc, BSc (Hons), PG dip, RGN, DN

Lecturer

I have been working with patients who
suffer from leg ulceration for seven
years. My first experiences were in
North Birmingham Community Trust
as a community staff nurse and then as
a district nurse involved in local leg

ulcer clinics. This work led to my involvement with the Tissue
Viability Team in 1998. Whilst working with the tissue viability
team I completed my Masters degree in Health Science. I
conducted a research project, which examined nursing care in
clinics and the home settings. This project and the part time
work with the tissue viability team led to me receiving the
Wound Care Nurse of the Year Award in 1999.

In 1999 I moved to London and established a Tissue Viability
Service for the Harrow locality. The service helped develop the
provision of leg ulcer services in the area. Use of a holistic
assessment chart and compression bandaging (for venous/mixed
aetiology patients) increased from 20% to 84% for all patients.
Inappropriate referrals to the vascular team were completely
eradicated. Providing hands on support and basic practice based
education for community nurses was the key to seeing changes
in the way they cared for patients with leg ulcers.

At present I work at King's College London as a lecturer in
Primary Health Care, teaching on wound management courses
and also working within the community with community
nurses. Areas of interest include lymphoedema, sickle cell and
the management of chronic non-healing wounds.

Conference Report

December 2000

Lynfa Edwards MSc, RGN, NDN, Cert Ed.
LUF Journal Editor

The first Annual Leg Ulcer Forum Conference of the new millennium was held at Ashford Hospital, Middlesex on 1 December 2000. The theme of the day was *Could You Live With a Leg Ulcer? – a Patient's Perspective*. As the title suggests, the aim of the day was for us to gain an insight from the patient's point of view of what it is like to live with leg ulceration.

The scene was set by the first session where a panel of patients suffering from current leg ulceration each gave an account of their experiences of how leg ulceration impacts on their lives. Julie Stevens chaired the discussion that followed. Some of the panel members were in their twenties, thirties and forties, which highlighted the fact that leg ulceration can afflict the young as well as the elderly of our society. We were honoured to have a member of parliament also on the panel. The members of the panel highlighted that leg ulceration had a great impact on their lives. With particular emphasis given to pain, fear, odour and impact on relationships, including work, social and sexual. There appeared to be a potential inheritance of the condition, two members recalled a parent and grandparent having leg ulceration. Each of the younger members highlighted their love of sport but due to leg ulceration were no longer able to participate in sporting activities. This session was indeed the highlight of the day (see page 7 for a summary of some of the panels experiences).

The following session given by Professor Christine Moffatt asked us to consider how we identify and manage the psychosocial factors of leg ulceration. With particular emphasis given to supporting patients with long-term ulceration, rather than setting unrealistic goals of ulcer healing (see page 20).

How many of you claim to have 'difficult patients' – for example, those who do not adhere to treatment regimes? Lynfa Edwards informed us about the perceptions of patients deemed non-compliant with compression bandages. She highlighted that patients' past experiences of their illness can impact on their willingness to adhere to treatments. For example, patients' interpretation of their illness can differ from health care professionals, which can create misunderstandings resulting in fragmented care (For an account of this presentation see page 11).

Pain continues to be a major component of suffering in those who present with ulceration of the lower limb. We were delighted when Dr. Hildegard Charles shared some of her findings of her research into this area of care. We hope to have a written account of her presentation in the next journal.

Mark Collier presented the next session, where he posed many questions about wound odour. Odour can have a profound impact on the patient's quality of life, which could adversely affect personal relationships. There are many issues that impact on the types of odour and treatment modalities. A reproduced article on the topic is written by Mark on page 12.



Delegates enjoy lunch and talking to company representatives

Following the AGM and a welcoming lunch, Dr. Patricia Price from the Wound Healing Institute, Cardiff introduced us to the concepts of *Body Image and Self Esteem*. Within her talk she defined the relationship between Self-Esteem, Self-Efficacy and Self-Concept. This is discussed in greater detail in a very comprehensive account of her presentation given on page 15.

Finally the later part of the afternoon encompassed workshops relating to *Scarring* facilitated by Gill Henn and Ian Scott and *Alternative Therapies* facilitated by Nicola Warnock (see page 18). Delegates attended each of the workshops and were encouraged to participate. The alternative therapy session included aromatherapy, reflexology and demonstrations on foot and lower limb massage.

In conclusion the success of the conference was reflected in the excellent evaluations we received from the delegates:

"Well organised and the presentation of topics are very informative and well presented."

"Very informative and interesting day. Excellent speakers, well presented and great to talk to nurses working with leg ulcers in other areas. Well organised. Thank you."

"Conference good; all sessions excellent and relevant."

Many questions were posed during the day, and highlighted the need for continued research to address areas relating to the impact of leg ulceration on a patient's life. Which leaves me with this question: how would you cope if you had a leg ulcer? We would be interested in your response.

Living with leg ulcers – *A Patient's Perspective*

**Ian Webb, Michael Price
and Miss Pauline Wright**
Leg Ulcer Patients

The following are excerpts from written accounts of patients currently suffering with leg ulceration. We would like to take this opportunity of thanking them for giving their personal accounts of what it is like to live with a leg ulcer.

Living with leg ulcers

Ian Webb: age 38

I hope to share my experiences on how I have coped with leg ulcers. I can remember as a little boy watching my grandfather mowing the back lawn on a hot summer's day, sometimes struggling to keep one leg in front of the other. My grandmother would watch from a distance in case he would fall. One day my curiosity got the better of me and I asked my grandmother why my granddad was limping, she looked at me and sighed "don't ever get bad legs". Of course, I did not realise that later on in life that statement would come back to haunt me.

By the time I was five years old, leg ulcers were about to hit the family again. One evening my mother, still quite young, recognised a mauve crescent shaped mark above her left ankle. From what I can remember within a year both her legs were ulcerated. The ultimate question now being asked, are leg ulcers hereditary?

Sport was to play a big part in my life, and having a brother two years younger playing soccer became quite a regular feature. I had reached the age of thirteen and I had to quit playing for a year, as I had developed a curvature of the spine and surgery was suggested to correct this. Following the operation I suffered severe fluid in my legs, the backs of my calves tightened up so much it became too painful to walk, nurses had to raise my bed to drain the fluid from my legs. After almost a year out of school, it was time to pick up the pieces. All of a sudden life seemed enjoyable, especially playing regular soccer, which kept up a good fitness level. However everything would seem to turn upside down by the time I reached twenty-one. I had finished my end of season soccer tour of Holland and Belgium and I had time on my hands to relax and unwind. One Sunday afternoon whilst sun bathing, my mother noticed on my left leg a mauve crescent shaped mark. I went to see my local GP and he seemed to confirm my worst fear, I had developed a leg ulcer. On telling the rest of the family, everyone was devastated more so my mother who felt so guilty and started blaming herself for what had happened. It was my own choice to give up playing soccer, with my left leg strapped up I knew I could never take the risk of a knock to the leg.

So began regular trips to my local surgery who had regular weekly clinics, I was given advice on what was best and what was not. I was told to watch my diet, keeping weight down would help to prevent further strain on my leg because the ulcer seemed small at the time I felt no pain or discomfort so wanting to walk anywhere was not a problem. Being able to wear long trousers seemed to disguise the problem with my legs. Within two months of quitting playing soccer, I was offered to take up coaching 5-7 year olds who had created a team for themselves. I grabbed at the chance after all I did not have to worry about getting my leg knocked. I was still able to do some running, so I did not feel totally handicapped. Through doing this I began to keep in shape plus build up a confidence, a voice in my head kept telling me "don't give up".

Another thing you adapt to is walking amongst crowds of people, being accidentally knocked in the street is something to be aware of. Because I was showing no signs of limping or struggling to walk, people in the street do not know you have ulcerated legs. I was able after a period of time to get my ulcer healed up and I was able to apply a dry dressing, tubigrip and support stocking. This lasted for about six weeks, then I had a setback, and the ulcer on my leg began to breakdown again. With my leg back in support bandaging, I was told by my GP that I should probably have to expect this routine for the rest of my life. Being that I was already suffering with a leg ulcer seemed to cushion the blow.

Within a year of my left leg breaking down, my right leg began to do the same. Just as it was with my left leg, same place. The breakdown happened in exactly the same place. This time I was going to go through the pain barrier, I was told by the nurse treating me that it has to do with the nerve ending in my leg. Taking painkillers helped me get through the days. But at the end of the day, I was walking in absolute agony; my social life took a back seat because I had trouble walking anywhere. By the time I was 25 I was transferred to an ulcer clinic at the West Middlesex Hospital at Isleworth. They could not believe how young I was to be suffering with such a condition. After all, the percentage of their patients was elderly. During this period of treatment I was to know what pain was all about. I can remember most weeks struggling to walk out of the clinic because I was walking in pain. The biggest asset was that I had learnt to drive so I was able to get around including getting to and from work. I was very fortunate at the time to have an employer who was very understanding about my situation. When telling him I was suffering with ulcerated legs there seemed to be a blank shocked look, but at the end of the day

every effort was put in to help me. I was so relieved to get home every evening all I wanted to do was stretch out on the bed and keep off my legs. My social life took a knock as well, sometimes when I really could have done with a night out I knew that I would never make it to the pub.

The one thing that I did manage to achieve was going on holiday. I was a bit unsure at the time considering the state of my legs but I was encouraged by the clinic to do so, I was told to try and live a normal life as possible and try not to let my leg ulcers dictate what I could or could not do. I'll tell you now it was the best thing I had done; all of a sudden I did not feel trapped anymore. I was given dressings to take and I spent two weeks looking after my own leg. In the Grand Canaries life was a lot slower so I found it easy to adapt to. Also staying on a large complex it was quite easy to at least make it down to the pool every morning. I even took the attitude that I was going to enjoy myself. The one thing I did notice was that nobody seemed to bother you. There I was in shorts stretched out in the sun with my legs bandaged up, but people around me never asked why I was in this situation. This was to boost my confidence and ever since, I have always tried to go abroad knowing that by being reasonably careful it is possible to go on holiday.

After roughly six weeks of coming back from holiday, both my legs began to improve. I found that being in less pain I could venture out often even though I was just venturing out to the pub, my social life began to take off. I was catching up with friends I had not seen in ages. This time I was determined to try and keep my legs healed. Being able to get my social life back on track, I was this time attracting the opposite sex, my first girlfriend actually worked for an airline. Amazingly despite the long haul trips, we seemed to develop a meaningful relationship. The thing that took me by surprise was that when I told her about my legs she seemed to understand. Like everything else nothing lasts, because of job commitment we split amicably and we are still good friends. I have had a series of girlfriends since, but at this moment in time the right one has not come along.

Despite having found out that I now suffer from deep vein damage to both legs, I seemed more determined to carry on a normal life as possible. Whilst I am capable of walking I try hard not to think what the situation could be like say in ten years time. You build up a sixth sense when you have ulcerated legs. You get to know when something is not right, you get to know when to rest up although I know at some point my legs will need attention, I am determined to experience a normal life as possible. Since writing I have probably thought of more issues to write about. I hope that what I have written so far can give encouragement to other people who have suffered the same as me.

My ulcer

Michael Price: age 41

I have had my ulcer on and off since 1986/7. I was told at the time that I had a DVT and I would have to have a vein strip operation on my left leg. I was told that this was not the sort of problem that would cure itself.

I was scared stiff beyond belief; as anyone who knows me will tell you that I cannot sit through a complete episode of 'Peak Practice' without at least looking away once.

I was booked into a private hospital at Ashstead, Surrey. The place was like a hotel, they were going to operate on ME on MY LEG. I was so afraid that I'll admit, I sat on the bed and cried. Later on the Surgeon who was to perform the dreadful act came to my room, my leg when he had finished with his marker pen looked like a map of the underground. The nurses and doctors were aware of my fear and were all very kind and reassuring. However, IT WAS MY LEG.

The next thing I remember, after the formalities of pre-meds, was waking up in bed, the operation was over, it could only get better now. I spent the next four days before discharge learning to walk again. .

Then my ulcers started. At first I didn't know what they were, some kind of spot perhaps. I went back to my doctor and was referred to Epsom Hospital where I was treated, but without much success. I stopped going after a while and started to dress my leg once a week myself using Viscous Paste PB7.

I later moved to the Sunbury area and started going to the Green Street Health Centre. Again the healing process was very slow. Occasionally the ulcer would heal for a while when it did break out again, I again would tend to it myself, still using Paste PB7, or Granuflex which I had been introduced to. Eventually after a period of perhaps two-three years, I was referred to the Moffatt Leg Ulcer Clinic at Ashford Hospital.

I remember well my first visit, I was petrified, tense and very afraid of the unknown, I had over the years heard of people having legs amputated, this thought didn't help calm me, after all, last time I had been in hospital, I had a vein strip. I was in quite a nervous state, and even considered walking out of the waiting room and going home. Fortunately I stayed, however when I finally went in, having been called, I was really worried. I didn't know anyone else that had a leg ulcer, but here there was a waiting room full of people with the same complaint, and a clinic full of ulcer specialists to help us. I think my first question was, will there be any injections, my second biggest fear after operations.

The nurse who tended me that first day was absolutely brilliant, realising my fears and trying to put me at ease. I was given a Doppler test and blood pressure check and my leg was dressed. I realised that I would have to attend this clinic on a regular basis, because as the past has proved, these ulcers don't just heal themselves and go away. Whenever I get a toothache or similar

complaint, I just go to the chemist and get some kind of pain killer and within a few days, the toothache is gone. But these Leg Ulcers are a totally different story.

Since I had been attending the clinic, the ulcer I had on my right leg healed at the first attempt and although I wear a support on it, I have not had any further problems, and it still remains healed to this day.

My left leg however, is the problem one. At times there have been two ulcers on it at one time. I dare say some people heal a lot faster than others and once healed, stay healed. I however appear to be a slow healer, with regular out breaks. When they open up they look really bad as if someone has taken an ice-cream scoop and taken a lump out of your leg. It then takes weeks before you see any change in the size, but once it starts to heal, I look forward to seeing how much it has reduced in size. I remember the times when my leg healed completely, it really is a good feeling. However you have to be more careful than most people, that you don't catch your legs on obstacles, a mere knock could cause the ulcer to re-open, I dread the time I will see a very small scab, for me this will signify another ulcer outbreak.

The things I miss doing most are sport, particularly football and swimming. Football of course is out of the question, but swimming, I'm told could still be enjoyed. However, I am too self aware of wearing an inflatable cover or large waterproof cover over my legs. For the same reason, I don't wear shorts anymore even if my leg is healed, I have very bad staining on my leg.

As far as work goes, the Company I work for have been very good to me over the amount of time I have had off over the year. However every now and then I am asked, "How is your leg", "Is it healed yet?" It is very hard for people who have not experienced a leg ulcer that it is not a normal open wound that heals within a week or so. When people in general ask, "How's the leg", I usually reply "Still following me about". After all these years I get tired of telling the same old story to people who would probably still not understand, and would ask the same question the next week. Bless them they mean well.

As far as relationships go, I have been with the same woman for about the last twelve years. She nags me to put my feet up if I were watching T.V.

We go on holiday and the only difference is that she will use the hotel pool and I won't. Everything else is normal believe it or not.

Last Christmas I had another drawback and spent about 9 days in Ashford Hospital with my second DVT. However, I will save that experience for my autobiography.

In closing, I would like to say a big thank you to Julie and Christine who have both been very kind and caring, and thanks to Janet for the tea.

Miss Pauline Wright: age 53

Pauline was born and bred in Tamworth, Staffordshire where she currently lives. Until September 2000 she was employed as a Senior Legal Advisor to Magistrates and worked in the South East Staffordshire Group of Magistrates' Courts and obtained the Diploma in Magisterial Law from Bristol Polytechnic in 1982.

Her retirement from full-time work on the grounds of ill-health, followed a period of sick leave of some seventeen months and a career in the Courts Service spanning some twenty six and a half years.

Pauline has suffered from chronic venous ulcers for the past 42 years, the first developing at the age of 11 years. Her understanding of why she suffers from venous ulcers is that she has congenital thrombo-phlebitis migrans (Protein C deficiency). This is controlled by medication, namely anti-coagulants and steroids, but she continues to be affected by the venous ulceration.

She is single, has one sister, brother-in-law, and two nephews – the boys being the family she never had (a very generous sister!). Pauline has many interests and leads a busy social life. She has been actively involved with voluntary work for many years, in particular the Citizens Advice Bureau.



I have suffered ulceration since the age of 11. I underwent an operation in 1958 to remove the main vein in my left leg 'to heal ulcer', the ulcer went from size of thumbnail to size of palm of my hand in two weeks; the ulcer remained open for 11 years. Worn bandages and support hosiery since aged 11. I have only been without ulcers for weeks, perhaps months

since then. Ulcers affect both legs, and it is rare for both legs to be healed at the same time. Could not do sports at school, remember clearly how I felt when not allowed by junior school to play a part (in costume) at school concert in case I knocked legs. Had taxi to and from school from aged 12 until left grammar school.

Not doing sports meant I did my work in the Library! All my friends did sports, and a forward-looking Gym teacher included me where possible so I, along with everyone else, learnt how to umpire tennis. I love tennis, only as a spectator (no hand to eye co-ordination). I was always told at school all I was good for was an office job (I wanted to teach infants – pre-7), so did a 12 month Secretarial Course, obtained typing & shorthand skills, and got myself a job at a local car manufacturing company. 8 years later, I decided I had to get myself a career, and applied in 1974 for an office job at my local Magistrates' Court. Did 5 years in the office, going to night school and obtained the A levels I needed to be accepted for the Diploma Course to be a

Court Clerk, a job I loved. Recently, I have been retired on health grounds after 26 years in the service. During the time I should have been going out and having a good time (my teens & early 20's) my legs were unmentionable. I qualified for Mobility Allowance (now DLA) because of the very short distance I could walk, stayed in a lot (nothing else) this culminated in my feet haemorrhaging when I was 21. I nearly lost my left foot, had 13 weeks in hospital on bed-rest. The underlying problems of the thrombosis are controlled by medication, I just keep taking the tablets!

I saw that my life was not going to be boyfriends, husband and children, so I made a choice of a career, and borrowed other people's children – nephews and 4 godchildren. I've always been told my medical problem was unusual in one so young, and even now at 53, I still get told it is an old person's problem. I lived at home with my widowed mother until her death 7 years ago. Somehow I never left; it was safer and easier to stay at home, and work took all my energies.

Since leaving work in September 2000 due to ill-health I am now in the middle of a new learning curve – Computer; CAB; Soroptimists. Emotionally, because I was told that I could never allow myself to get pregnant, I chose to follow a career and I know emotionally I've built a very high wall around myself. I do let my guard down on occasion, only to get hurt, saying that if someone thinks enough of you I know they don't see the legs as a problem – they are just part of me, and if you care for me that has to include the legs and all that means!

I've spent £2000+ on a bed; resting my legs whenever possible; avoiding standing for any length of time; regular blood tests; not able to have a bath – boy, when I progress to elastic hosiery, I shall lock my door, run the bath water, pour the largest G & T, remove the bandages, and wallow. Am I the person I am because of the ulcers or in spite of them? I am a Leo, so I either purr like a pussy cat or roar like a lion. All I have ever tried to do is be just like everyone else, yet I am unique, like we all are. I've always tried to put something back. I sometimes think I am a mixture of Claire Raynor and Marge Proops. I can be very up or very down. Only my family have really seen my down phases – not nice. The last 18 months have been especially difficult, yet I've come through because of a lot of help from friends and professionals. As Jesus closes a door he always opens a window!

I get frustrated by the medical profession – at 11 years of age I had the operation to remove the main vein from my left leg to heal the ulcer; earlier this year my consultant (a young doctor) told me that was the worst thing I could have had done (but in 1958 it was the solution being offered and you trust doctors to do the best for you, so my mum gave her consent)

All anyone can do is the best that is available at the time. The haematologist who cautioned against having a family, told me some years later (I was in my early 40's) that it was a pity I'd never tried to have a child, he was sure he could have got me through the pregnancy. I can't begin to explain properly how that made me feel. There has never been an occasion where I was committed to anyone, where I wanted to find out about the possibility of having children, but I feel that I made a conscious decision not to go one way, but to opt for second best of a career. Anyway any children I had would have had to have stayed in a playpen until the age of 18. I have a wide circle of friends, am busy with my many interests, and generally enjoy life. I feel I am missing out on part of life – how do I change that – I feel I have to like myself a lot more. I find that when my legs are bad I think about them constantly; when they are healed I think about them constantly because I am waiting for them to break down again. When I feel optimistic I do things – if I wait for the legs to be healed before I did anything I'd never do anything.

I wonder whether I am the person I am because of my legs or in spite of them! I am sure if you cut me open I would have venous leg ulcers in capital letters throughout just like Blackpool rock!



LUF Patient Panel discussion, facilitated by Julie Stevens

Views of patients deemed *non-compliant*

Nurses often talk about the ‘non-compliant patient’, one that is perceived to be a ‘difficult patient.’ However, how many of you have explored the reasons why these patients are so ‘difficult’? This paper introduces a number of concepts gained from patient interviews. It explores some of the perceptions of patients suffering venous leg ulceration who are ‘deemed to be non-compliant’ with compression bandaging.

The author acknowledges that there are a number of phrases used interchangeably with the term compliance, eg adherence and concordance, these terms identified in the literature have similar meanings. For this article, compliance will be used as a term to describe the maintenance of health behaviour; however, the limitations of the term are acknowledged.

Most of the research relating to leg ulceration has taken a biomedical approach, ie focused on treatment modalities. A number of quality of life studies using quantitative methodology have demonstrated that leg ulceration can have a profound effect on patients’ lives (Philips et al, 1994; Price and Harding, 1996). However there is a paucity of evidence that gives us a patient’s perspective of what it is like to be that person living with a leg ulcer.

Venous leg ulceration is often seen to be a chronic intractable problem. It has been identified that 50% of patients suffering with chronic health problems do not comply with medical regimens...

What do we mean by the term compliance?

According to Fletcher’s (1989) definition ‘patients do what the health care professional wants them to do’. This implies that patients should be passive towards their health care professional, suggesting that a power relationship exists between the health care professional and the patient, which in turn could have a detrimental effect on delivery of care. Conversely non-compliance occurs when ‘A person’s behaviour does not coincide with medical or health advice, the extent of which is variable’ (Cameron 1996). However if a patient adheres to a treatment regime this in itself does not guarantee that the patient’s leg ulcer will heal. If the patient does comply with a treatment regimen it does not necessarily suggest that their quality of life is going to improve. The following gives a brief account of findings taken from a study that explored the perceptions of ‘non-compliant’ patients, all patients (13 women and 1 man of varied age) had been treated with four layer bandaging.

Cause of Leg Ulcer

Half the patients attributed the cause of their ulcer to a knock or scrape, suggesting that the cause was outside their control. The cause of the ‘knock’ varied from a Sainsbury trolley to catching their leg on a bicycle chain.

Concurrent Problems

Patients expressed how their leg ulcer had inversely impacted on their lifestyle. Pain was experienced in all the patients and for many pain was a reason for removing the bandages. Restriction in mobility, leakage of exudate and infection were distressing factors for some patients.

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Dilemmas of Treatment

The duration in which patients managed to tolerate the bandages varied from one day to ten weeks. The majority of the patients admitted to cutting off the bandages. Some interfered with the bandages and others refused to have them applied. The reasons for this were attributed to sleep disturbance, itching and problems with footwear.

Perceptions of Health Care Professionals

The majority of patients had received treatment both in hospital and the community. They acknowledged their gratitude to community nurses; however a lack of empathy was also apparent. The patients did not always agree with the information health care professionals provided them with.

Perceptions of Leg Ulceration

Altered body-image and the adverse effects on femininity were areas of concern for these patients. For one patient the ulcer felt dirty, for others the ulcer was a result of bad luck or fate. They didn’t believe that their ulcer would ever heal. The fear of potential amputation of the leg appeared to be a threatening phenomenon.

Health Education

Very few patients had received information relating to leg ulceration. One patient who had received information suggested that it was ‘gobbledy-gook.’ It would appear that this group of patients are potentially affected by their past experiences and situations which in turn have altered their emotions and influenced their present actions. The patients’ intolerance of the four-layer bandage system was associated with pain and other concurrent problems. It could be suggested that health care professionals need to gain a better understanding of the perception of patients in relation to their condition and treatment.

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Measuring Health Related Quality of Life in Patients with Chronic Leg Ulcers Wounds

Malodorous and infected wounds: *A patient-centred approach*

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What do we mean when we talk about malodorous wounds? A useful patient-centred definition is made by Neal (1991) who described them as ‘any wound assessed as being offensive (smelly) by the patient, carer or practitioner’.

When health professionals look at making their own assessment of wounds, the wounds they most commonly assess as being malodorous tend to be malignant lesions, leg ulcers and pressure ulcers. However, the types of wounds described above are not necessarily always offensive smelling, so just what makes a wound malodorous?

A common method of trying to rate a wound for malodour is described in *Table 1* (Haughton & Young 1995).

Table 1.

ODOUR ASSESSMENT SCORING TOOL

Score	Assessment
Strong	Odour is evident on entering room with dressing intact (2-3m from patient).
Moderate	Odour is evident on entering the room with the dressing removed (2-3m from patient).
Slight	Odour is evident at close proximity to the patient with the dressing removed.
No odour	No odour is evident even at the patient’s bedside with the dressing removed.

From Haughton & Young (1995).

Pathophysiology of Wound Odour

Malodour is associated with the metabolic end products of anaerobic activity, such as propionic, isobutyric and butyric acids.

Malodorous wounds are usually polymicrobial, meaning that they contain at least two anaerobic as well as aerobic bacteria. Moody (1998) found that two thirds of clinically significant anaerobic infections typically involve up to five anaerobes.

Infection plays a significant role in the development of malodour, partly because of the effect that infection has in delaying wound healing. *Staphylococcus aureus* B-haemolytic streptococcus and pseudomonas in particular have been

identified as delaying the rate of healing of leg ulcers (Gilliland et al, 1998).

Whether a wound is infected can often be diagnosed by clinical observation alone. Factors that help arrive at the diagnosis include a lack of progress towards healing or observation of granulation tissue developing an unhealthy red colour. There is a tendency for superficial ‘bridging’ of granulation tissue along with increased pain and increased exudates (Cutting & Harding, 1994).

The wound odour itself tends to depend on the type and dominance of the pathogens present. These can be identified through a range of tests ranging from bacteriological swabs and tissue cultures to multi-element odour detection (Parry & Oppenheim, 1995; Hampson, 1996).

Exudate

The amount and type of exudate produced by wounds that become malodorous is worthy of investigation.

A sudden increase in exudate production can be the result of large numbers of bacteria in a wound, as capillary permeability will be altered - an early sign of infection. The amount of exudate within a malodorous wound needs to be carefully assessed, as it will determine interventions. It is worth remembering that stagnant exudate alone can cause wound odours (Neal, 1991).

Composition of Exudate

Exudate is essentially blood from which most red cells and platelets have been filtered out. The number of white cells present can be up to six times greater than normal. Blood glucose levels tend to be lower, and the wound fluid also contains proteolytic enzymes (Wysocki et al. 1993).

McLaren (1992) found that there is typically a high loss of



protein in exuding pressure ulcers. Excessive exudate can lead to maceration and excoriation of the surrounding skin which in turn may lead to the onset of infection.

Assessment of Exudate

The traditional method of recording amounts of exudate loss can be highly unsatisfactory. There is certainly no research basis for the traditional



subjective method of estimating exudate loss, by reducing one +, two pluses and so on.

Thomas et al (1996a) highlighted that even highly experienced nurses were unable to classify wounds accurately according to objectively measured quantities of exudate production.

Treatment

The primary treatment objectives are to:

- Inhibit anaerobic/aerobic activity at the wound site.
- Reduce/suppress odours associated with the wound.
- Debride necrotic/sloughy material within wound margins.
- Improve patient's psychological perspective of the wound.
- Manage exudate – improve patient's quality of life.
- Prevent further tissue breakdown/complications.
- Optimise patients' healing potential.

Management of Malodorous Wounds

The most effective way of managing malodorous wounds is to prevent or eradicate the infection responsible for the odour. In order to do this, we need to use one or a combination of the following treatments:

- Administer systemic antibiotics or antimicrobial agents.
- Topical application of metronidazole (0.8%) in a hydrogel, such as Metrotop.
- Consider the use of less conventional topical applications, such as honey/sugar preparations or larval therapy.
- Use primary odour absorbing wound dressings.
- Mask odour - this could be through a number of methods including complementary therapies or air fresheners.

Metronidazole Gel

Research, including that of Thomas and Hay (1991), has shown that metronidazole (0.8%) gel is effective in the treatment of both anaerobic and aerobic infections, and there is much

anecdotal evidence to support its use. The gel is available as Metrotop (SSL International, Toft, Cheshire) which is applied directly to the wound surface after 'cleansing'. Flat surfaces should be generously covered with the preparation. The treated wound should be covered with an appropriate secondary dressing. There are no undesirable side-effects reported to-date.

Other Topical Applications

Honey: Some varieties e.g. Manuka Honey from New Zealand, have been found to contain potent antimicrobial agents.

Sugar: This inhibits bacterial growth because of the hyperosmotic environment produced by high concentrations.

Yoghurt: Applied in an attempt to encourage an overgrowth of pathogenic organisms by lactic acid bacteria such as *Lactobacillus bulgaricus* (Chirife, 1983).

Larval Therapy

The use of maggots in wound treatments has been shown to be an effective way of eliminating infection and odour from necrotic wounds. More information on this can be obtained from the Surgical Materials Testing Laboratory at the Princess of Wales Hospital in Bridgend (Thomas et al, 1996b).

Odour-Absorbing Dressings

These incorporate an activated charcoal cloth. They are produced by carbonising a suitable cellulose fabric by heating it under carefully controlled conditions.

These products vary in structure, composition and ability to cope with wound exudates. However, most are placed in direct contact with the wound while others are used as secondary dressings. These dressings draw the odour and filter it through the charcoal layer, often completely masking or neutralising the smell.

A good example is Carboflex (ConvaTec, Uxbridge) which is a multi-component dressing consisting of a wound contact layer (alginate and carboxymethylcellulose fibres) bonded to a plastic film. Behind this is a layer of charcoal cloth and absorbent mixed fibres within a second 'plastic' layer.

Management of Infected Wounds

The management of an infected wound that gives rise to malodour (figure 1) consists of the administration of systemic antibiotics or antimicrobial agents (Harding, 1996: Copper and Lawrence, 1996). It is important to be aware of sensitivity, resistance and toxicity issues.

In conjunction with these treatments, antiseptics and disinfectants should be used to promote and maintain a clean environment. Antiseptics are usually applied to living tissue whereas disinfectants are applied to inanimate objects such as work surfaces.

Neither antiseptics nor disinfectants achieve complete destruction of all microorganisms present. Some products, in some circumstances may damage host tissue, so their use needs to be monitored and changed or ceased if necessary.

Environmental Conditions

Hand washing is perhaps the most important factor as far as infection control and wound care is concerned. Where possible, specially designed rooms incorporating ‘plenum’ ventilation can minimise the risk of airborne dispersal of bacteria.

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Did you know?

In 1866 John Gay, through detailed autopsies, consolidated the view that varicose veins and ulcers are closely linked but also that ulcers occur in the absence of varicose veins. He noted that patients who had both were more difficult to treat.

Body-Image and *Self-Esteem*

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The application of the concepts 'Body-Image' and 'Self-Esteem' to patients with leg ulceration is both difficult and complex. Whilst there is a body of literature on each of the concepts, neither has been applied to this patient population to any great extent. Within this paper I will attempt to define both terms, discuss the relationship between these concepts and look at some studies completed in this area.

Lacey and Birchnell (1986), Cumming (1988), Brown et al (1990) and Newell (1999), have all argued that one of the main problems in the literature associated with body-image, particularly outside the area of eating disorders, is that the construct has been used in a loose and ill-defined way. As the term is not operationalised consistently, the literature has become confused in some areas. Body-Image was described first in the 1920's by Head, but this was from a neurological perspective; he defined Body-Image as the unity in the sensory cortex developed from past and current body sensations. There is little attempt in his definition to go beyond the location of these sensations within the brain. It is not until the work of Schilder (1935), that the construct goes beyond the purely physical. Schilder (1935 cited in Dewing 1989) defined Body-Image as 'the picture of our own body which we form in our own mind, that is to say, the way in which the body appears to ourselves'. Here Body-Image was described in an inclusive way incorporating somatic, psychological and social aspects of self but it is not until the writings of Goin and Goin (1981) that Body-Image incorporates the emotional significance that we attach to various physical parts of our bodies.

However, it is the definition of Body-Image by Price (1990) that is most familiar to nurses: 'Body-Image is the totality of how one feels and thinks about one's own body and its appearance'. This definition is summative of the work that has gone before, but is also ground breaking as for the first time three elements of Body-Image are incorporated: body reality, body ideal and body presentation. Much of Price's work has focused on how these three elements relate to one another; Price sees the elements existing in a state of tension or balance which together make up a satisfactory Body-Image which humans strive to maintain. The model is important as it is one of the few that goes beyond mere description of the construct; it has gained a high profile amongst British nurses, not least because it is closely tied to clinical practice. However, many of the assumptions behind the model have not been tested empirically and as a result, writers such as Gournay et al (1997) state that the model is purely speculative.

The list of factors affecting the development of Body-Image are numerous, but include genetics, socialisation, fashion, peer groups, cultural influences and messages delivered through health education. We enter adulthood with a relatively static perception of our own body and its image. However, whilst age may not be associated with negative Body-Image (Janoff-Bulman, 1992), there can be little doubt that any 'significant alteration to Body-Image occurring outside the realms of expected human development', (Price 1990), will lead to a range of psychological reactions. The work in relation to 'altered Body-Image', has focused on the impact of trauma, acute wounds and disfigurement, a review of which can be found in Magnan (1996). The work of Papadopoulos and Bor (1999) has outlined the potential impact of poor Body-Image on behaviour in patients with chronic skin conditions (See Table 1)

Table 1: Responses of those with poor Body-Image

1. Edit out social experiences to reinforce existing negative perceptions of self.
2. View their bodies only as aesthetic objects.
3. Minimise other positive aspects of their appearance.
4. They have a heightened sense of body awareness.
5. They comply with narrow social standards in terms of what is attractive.

With regard to Self-Esteem, writers such as Bandura (1997), and Neil and Barrell (1998), have argued that there is a lack of clarity between the concepts of 'self-efficacy', 'self-esteem' and 'self-concept', whereby researchers and clinicians use the terms interchangeably even though they are not the same. *Figure 1* defines these concepts and whilst it is clear that both self-efficacy and self-esteem relate very closely to self-concept, the relationship between the ability to perform tasks and the self-worth associated with those tasks results in a variable relationship between self-efficacy and self-esteem.

The relationship between these aspects of self is complex. The work of Bandura and colleagues has identified a set of circumstances in which the likelihood of feeling a sense of worthlessness may be exacerbated: individuals who have limited competencies in those aspects of life that they hold important, plus, they have exacting standards in terms of self-evaluation, plus, they belong to a socially or culturally

disparage group or minority, are much more likely to experience poor self-esteem. In order to maintain a high sense of self-esteem individuals must not internalise the negative reactions of others and remain confident about their ability to cope. Papadopoulos and Bor (1999) have shown that those who are able to maintain high self-esteem, whilst experiencing severe dermatological conditions, believe that the negative reaction of others, says more about those 'others' than about themselves.

Many of the writers already cited in this article would argue that Body-Image is closely related both to self-concept and self-esteem. Certainly self-concept and Body-Image are both influenced by how positively or negatively others appraise us in both our social and cultural environment. Rogers (1961) defined self-esteem as 'the extent to which our real self measures up to ideal self, and the way we are perceived by others'; a definition not dissimilar to that proposed by Price (1990) for Body Image. When discussing Body-Image, Papadopoulos and Bor have argued that dissatisfaction with a particular aspect of self has been found to cause an overall reduction in self-esteem, such that a failure to live up to an ideal self-image in an area considered important can be damaging to self-esteem.

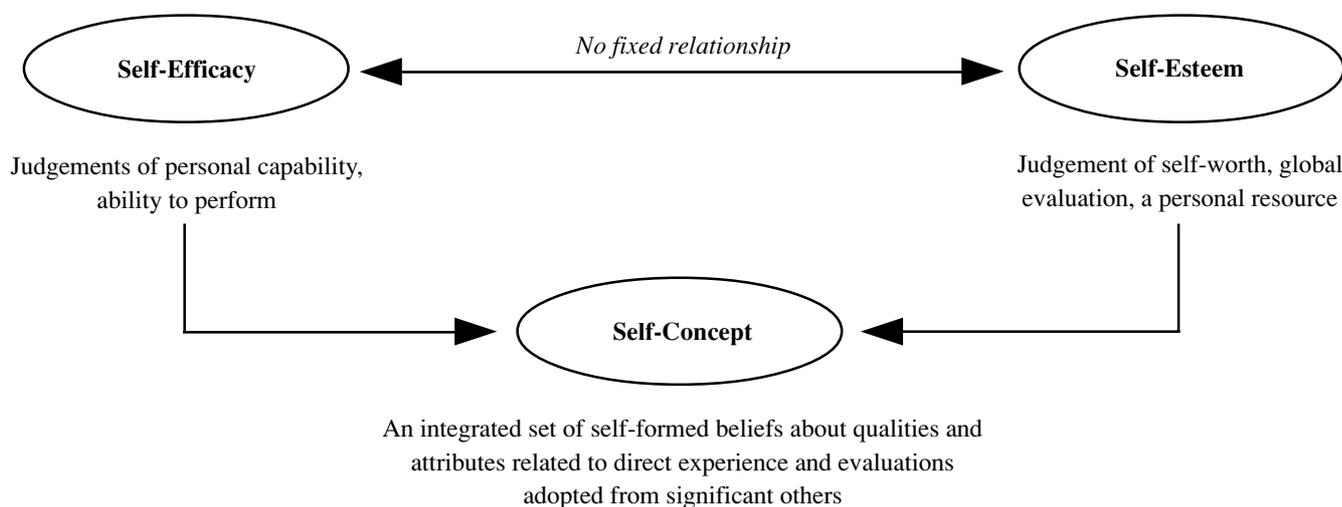
Self-esteem is a personal resource that may moderate the effects of disfigurement, incapacitating illness, and injury or threatening life events. We know that an altered Body-Image can lead to a negative self-esteem in patients who experience acute wounds following trauma, those with dermatological conditions and those that live with long term disfigurement. So where does this leave us in investigating patients with leg ulceration? Many of the studies that have focused on quality of life issues in patients with leg ulceration have indicated that a poor Body-Image or poor self-esteem may follow as a consequence. However, very often, these are reported incidentally to the quality of life data (Walshe 1995; Phillips 1994). In such studies the anxiety or depression that is reported following leg ulceration may be due to any number of symptoms or related to the overall impact of the experience. To exemplify studies that have attempted a more focused investigation of Body-Image/Self-Esteem, the following two studies are presented.

In 1998 Neil and Barrell reported on their qualitative study of a convenience sample of 7 patients who were interviewed for approximately 30 minutes. Their chronic wounds had been present for >2 months but <1 year. The basic premise for this paper is that an alteration in Body-Image as a result of a chronic wound fits the transition theory of Florence Selder (1994). This theory has been developed to explain the process of restructuring reality that follows a period of uncertainty. Neil and Barrell conclude that people with chronic wounds face significant transitions in their lives. They experience a period of disrupted reality when their wounds do not heal and this is followed by a period of uncertainty when the individual must face a range of interventions that lead to frustration with lack of healing. During this period of uncertainty individuals may experience denial, anxiety, pain, immobility, and altered Body-Image. Neil and Barrell conclude that changes in Body-Image can be part of this process.

Whilst this paper is important, as it attempts to address Body-Image specifically, it is unfortunate that the results are confounded by the large range of wound types included; individuals with amputations and abdominal wounds were included in the study, so that changes to Body-Image were in fact accompanied by very real changes in body reality. The patients were also taken from a tertiary centre where they were still receiving treatment, which means that only 1 of the 7 interviewed had reached a period of 'reconstructing their reality' and therefore the support for Selder's theory is incomplete.

In 1994 Flett, Harcourt and Alpass presented the results of a study to investigate self-esteem as part of a wider study looking at perceived psychological well being and health status. A convenience sample of 14 patients with leg ulcers and 14 matched controls, were asked to report on level of disability, psychosomatic symptoms, overall health status, loneliness, quality of interpersonal relationships and self-esteem (using the Rosenberg Self-Esteem Scale). The results indicate that those with ulceration had experienced significantly more pain in the last 3 months ($p < 0.01$), significantly more health worries ($p < 0.05$) and were significantly less mobile ($p = 0.02$). There were no differences between the groups in terms of loneliness,

Figure 1: The Relationship between Self-Esteem, Self-Efficacy and Self-Concept



quality of relationships, positive affect and life satisfaction. However, there were significant differences in terms of self-esteem ($p < 0.01$) and negative affect ($p < 0.05$).

The study has a number of limitations, including the small sample size (which raises issues of statistical power), the ulcer patients were not a random sample and therefore may not reflect the responses of all elderly patients with lower leg ulceration, and no attempt was made to classify ulcers according to size, type, chronicity or other relevant variables. However, the study is important in terms of the specific inclusion of a scale to measure self-esteem.

In summary, it is evident that in the area of Body-Image and self-esteem in patients with leg ulceration, the findings are very limited. Whilst this paper does not include an exhaustive presentation of findings it does indicate that there is confusion about the concepts under discussion and we must be careful not to come to conclusions about the experiences of leg ulceration until more data are available to us. Whilst all papers finish with the conclusion that 'more research is needed', the paucity of the findings reported here suggest that this is not a routine conclusion but a genuine call for those concerned about such issues to investigate the area with rigour.

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Did you know?

Spender, in 1835, was one of the first people to believe that ulcers were caused by varicose veins.

The use of Complementary Therapies *in Leg Ulcer Management*

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I was invited to speak at the Leg Ulcer Forum at Ashford Hospital, Middlesex, on 1 December, 2000. The subject: The place of Complementary Therapies, mainly massage, in the management of leg ulcers. Two informal half-hour workshops were held at the forum, inviting questions and answers and ending with a short demonstration of a foot and lower leg massage to two eager and willing attendees. It was towards the end of a long day and aching legs were not in short supply!

I am a qualified Pharmacist and member of the Royal Pharmaceutical Society of Great Britain since 1990. I am also a fully qualified Aromatherapist and Reflexologist since 1992. I practise all three professions, working as a locum pharmacist in three pharmacies in West London two and a half days a week and the rest of the time I see clients for aromatherapy and reflexology at my private practise.

The aim of the workshops was to provide information on a level everyone could understand and enable them to take some practical advice away with them to use in their work as well as to highlight how a future of integrated healthcare may lead to wider use of complementary therapies in leg ulcer clinics in the future.

It was very encouraging to discover that some of the nurses present worked in leg ulcer clinics that already provided some sort of basic massage treatment as part of their service to patients. Others told me they perform a simple massage of about five minutes when changing patients' dressings and applying emollient creams. They had not been formally taught massage, but knew the basic principles of strokes in the direction of blood flow, kept it gentle and simple and did not try anything beyond their limited knowledge. As they found it greatly benefited their patients, the nurses were certainly keen to be shown more and be able to improve and expand this aspect of their treatment. Feedback from patients included reports of relaxation and reduced pain.

It is well known that improving the circulation helps to promote healing of a leg ulcer. The elderly make up a large proportion of leg ulcer sufferers because of poor healing due to age, a generally more sedentary lifestyle than younger people and weakened veins with a higher incidence of valve damage/inefficiency. Damaged valves allow pooling of blood in the lower limbs and this impedes the return of venous blood to the heart. As the force of the pumping heart has become insignificant in the veins of the legs, contractions of the leg muscles surrounding the veins play an important part in pushing blood back up the legs towards the heart. The more sedentary a patient's lifestyle or the more overweight they are, the more the circulation is impeded.

This is where massage can really help. In a way it physically 'mimics' the actions of the legs muscles. By massaging from the foot upwards with an even pressure and gentle squeezing of the calf muscles, the blood in the veins is encouraged to flow upwards in the direction of massage. Oedema can be effectively reduced and regular massage can significantly improve blood flow and the condition of the skin. The patient, relative or carer can be taught to give a gentle, basic daily leg massage for continual benefit, whilst nurses can give a longer, 'booster' massage during their visits.

Reflexology

As well as massaging the leg itself, the foot can also be massaged alone or at the same time as the leg, or reflexology can be applied to the foot. Reflexology involves the use of accupressure applied to specific points all over the foot via thumbs and fingers. Reflexology improves circulation, reduces stress and tension, helps the body to eliminate 'toxins' and waste products and helps the body to balance itself. It is excellent for reducing oedema in the legs, feet and around the ankles thus 'freeing' the circulation and localised movement.

Psychological Effect

Leg ulcers are often very unsightly and the patient may have a poor body image leading to low self esteem and lack of confidence. Depression may also ensue, especially where healing is particularly slow. The simple 'laying on' of hands through the touch therapies can do much to improve these symptoms. The fact that someone takes the time to touch and massage the area around a leg ulcer can be like a 'vote of confidence' to the receiver. The feeling of caring is emphasised and this can do much to boost a patient's self esteem and improve their self-image. A happy and positive patient is more likely to heal quicker. The mind and body are powerfully connected and complementary therapies focus very much on this holistic emphasis.

Massage

Not only can massage help to 'shrink' an ulcer, but the surrounding skin, which may be in a poor condition due to eczema, dryness or cellulitis, may also improve in texture and colour.

In terms of massage technique, strokes are not passed over the wound itself, but applied to unbroken skin from below the ulcer, then passing around the wound; one hand passing on either side and continuing the stroke upwards above the ulcer to the knee. A margin of one or two inches is left around the wound site to prevent further damage to the affected tissue.

Contraindications to massage include:

1. Severe inflammation, infection, broken skin heavy or widespread bruising. As explained, such areas should not be massaged directly over, but massage around wound sites is allowed if there is enough unaffected skin present. Or consider performing reflexology alone.
2. Recent fracture.
3. Varicose veins or recent scar tissue – treat with care and very low pressure.
4. A cut, open wound or infection on the therapists hands.

The massage can be performed using a simple emollient cream, such as aqueous cream or a base massage oil (with or without the inclusion of essential oils), such as sweet almond or wheatgerm oil. Where nut based oils are selected, check with the patient for nut allergy. A moderate amount of oil should be used to allow smooth, gliding strokes without dragging the skin, but never leaving ‘puddles’ of oil. Never massage without some sort of emollient as this may chafe the skin and cause further discomfort. Reflexology may be performed on the feet using cream or a fine, silky talcum powder, applied sparingly.

The strokes used would be mainly effleurage. That is, long, smooth, sweeping strokes with the palms of the hands rather than percussion movements, which are like drumming, tapping and chopping the skin surface. The pressure used depends on the individual. It must be gauged by their fragility or robustness, how much pain they are in, how much healthy flesh and muscle is present. Start lightly and gradually increase the pressure in small increments asking the patient to tell you when it feels effective yet comfortable and not painful. It is very important to get patient feedback. Use a firmer pressure over muscles e.g the calf, and ease up on pressure where the skin is thin or delicate e.g backs of knees and over bony areas. Pressure is applied on the upward stroke. You can still stroke back down against the skin to maintain continuity, but only with a feather light touch and no pressure applied. As well as the palms of the hands the thumb and forefinger separated to form a V-shape can be a useful technique for narrower areas and for very small on-the-spot treatment the thumb or finger pads can be used alone.

If essential oils were to be included in a treatment, the following would be useful: these lists are not exhaustive

Antiseptic: Thyme, Lemon, Tea-Tree, Lavender, Chamomile, Geranium, Benzoin, Myrrh, Tagetes.

In fact most essential oils have some antiseptic activity, but these are particularly notable.

The healing properties of Lavender oil were discovered by accident in the late 1920's by a French chemist called Rene Gattefosse, who then coined the phrase aromatherapie. He badly burned his hand whilst working in the laboratory of a perfumery and plunged his hand into the nearest bowl of liquid, which

happened to be neat lavender oil. Over the next few days he observed that his hand healed very quickly and with virtually no scarring. He began researching lavender and other essential oils and discovered their healing properties were due to their complex chemical make up. Lavender is one of the few oils that can be used neat on the skin and is a useful oil to have in your kitchen or first aid kit to be applied immediately to minor burns and wounds. Try it and you will see how beautifully and quickly the skin heals.

After the King's Cross Underground fire disaster, a well known British aromatherapy school and oil manufacturer supplied vats of pure lavender oil to hospitals treating the burn victims, for bathing and application to the burned skin to aid healing, reduce pain and help relieve itching.

Pain relievers: Anaesthetic: Clove, Cinnamon, Peppermint; **Analgesic:** Basil, Bay, Black Pepper, Cajuput, Camphor, Chamomile, Eucalyptus, Ginger, Lavender, Rosemary – to name but a few! **Anti-inflammatory:** Chamomile, Clary-sage, Fennel, Lavender, Myrrh, Tagetes, Yarrow; **Antipruritic:** Chamomile, Lemon, Terebinth; **Antisclerotic:** Lemon; **Cicatrissant:** Bergamot, Chamomile, Clove, Cypress, Frankincense, Juniper, Lavender, Rosemary, Sage, Terebinth, Tea-tree.

It should be noted however, that essential oils are naturally heavily perfumed and therefore not suitable for skins with allergies to perfume, natural or chemical.

Finally, the following passages have been taken directly from a book called 'Aromatherapy for Health Professionals' by Shirley and Len Price to demonstrate the use of aromatherapy in real clinical situations involving wound healing:

Case 4.2: Aromatherapist: Ulrike Radlein SRN, Germany.

A 45-year old woman had a motor vehicle accident, resulting in a comminuted fracture of the ankle. It was operated on but the operation site became infected and was open for four months. At this stage I was asked if I could try and treat the wound with essential oils. The orthopaedic surgeon gave his permission and before I started I took a wound swab for microscopy, culture and sensitivity. On the wound swab Staphylococcus aureus, Streptococcus pseudomonas and Escherichia coli were isolated and from this I formulated my programme. This treatment consisted of a daily footbath with 3 drops each Thymus vulgaris (thyme) ct. alcohol, Citrus limon (lemon) and Melaleuca alternifolia (tea-tree) (the essential oils were put on a small spoon of salt as an emulgator and then put into the water). The wound was then cleansed with dry compresses, and a gauze (on which was put 3 drops of tea-tree) put on. This acted as a compress and was covered with a mull bandage; this change was carried out once daily.

During the treatment the patient was given no antibiotics and only 20 drops Tramal (Paracetamol) when it was needed for her

(Continued at the bottom of the next page...)

The psycho-social effects of *leg ulceration*

Christine Moffatt MA, RGN, DN
Professor of Nursing
Co-Director for the Centre for Research
and Implementation of Clinical Practice

Professor Christine Moffatt highlights a number of issues raised from her research presentation on the psychosocial effects of leg ulceration.

How often do we truly consider the impact that leg ulceration has on patients and families? This is an important question that we sought to examine in a study seeking to identify clinical and psychosocial factors affecting healing, and the impact that not healing has for patients.

The study found a number of factors such as pain and depression were associated with delayed healing. As nurses we have a responsibility to ensure that we take a holistic approach to our patients. How often does that really happen in the field of leg ulceration, with its reliance on technical data and medical information? This study challenged us to begin to broaden our research horizons and to look for factors in the patient's psychological and social arena that may impact on healing. Important problems such as social isolation and levels of pain may require different management strategies to those used before. Are we ready and open-minded to these issues?

Non-healing doesn't just affect patients. This study highlighted how difficult professionals find not being able to bring about healing in an evidence-based culture which suggests that with the right care success will follow.

We are entering an era in leg ulceration where we must seriously turn our minds to how to help the patients whose ulcers don't heal. Maybe the emphasis will change – to supporting patients with a chronic illness rather than focusing on unrealistic goals of healing.



Professor Christine Moffatt addressing the LUF Conference

(...Continued from previous page)

pains. After 3 days she no longer needed any analgesic. Two weeks later, when a wound swab was tested none of the original bacteria were present. The wound closed after 3 weeks of using aromatherapy.

Pressure ulcers

This is an area where traditional medicine has limited success and nurses using aromatherapy have been rewarded by the healing which has occurred with the use of essential oils.

Cicatrissant oils together with those that are strongly antiseptic can be used in a spray with water when sores are suppurating – 10 drops in 100ml water, shaking well each time before

spraying the area. If it can be touched, gently apply a little from a mix made from 5-8 drops in 50ml of base oil of Calendula, which itself has cicatrissant effects on wounds and persistent ulcers. Calendula oil will also help to strengthen the skin if the mixture is massaged in gently twice a day. Compresses may be useful, but check that the dressing used is non-stick.

Recommended essential oils include *Boswellia carteri*, *Chamomilla matricaria*, *Lavendula angustifolia* (Lavender), *Lavendula x intermedia* 'Super' (Lavandin) and *Pelargonium graveolens* (Geranium). The cicatrissant qualities of the resinoid *Styrax tonkinensis* (Siam Benzoin) may also play a part in healing.

Joining the *Leg Ulcer Forum*

Membership of the Forum is free of charge to professionals involved in the prevention and treatment of leg ulceration. If you are interested in joining, please complete the following membership form and return it to:

The Leg Ulcer Forum

PO Box 337

Hartford

Huntingdon

PE29 1FX

Membership includes

- Mailing of the Leg Ulcer Forum Journal (Spring and Winter editions)
- Educational leaflets*
- Annual Conferences* and other LUF Meetings (reduced rate)
- Annual Forum Update

** Denotes a small charge*

Membership Form



President: Prof.C.Moffatt

(Please use CLEAR block capitals)

Name _____

Mr / Mrs / Miss / Ms / Other

Job Title _____

Address _____

_____ Post Code _____

Do you lead, or are you regularly involved with a specialist Leg Ulcer Service?

Would you like your details entered on our database? Yes

(A short form for completion will be sent to you)

Guidelines for Submitting Articles for Publication in

the Leg Ulcer Forum Journal

Once you have decided to write an article for the leg ulcer forum journal, make sure the content is appropriate for the readers. The following gives guidelines for authors.

Format

• Front page

Title of article

State author's name/s, qualifications, position, and place of work. Name, address and contact telephone number of the author responsible for correspondence.

• Introduction

This should be approximately 30 words in length. It should introduce the reader to the areas covered in the article.

• Headings

Headings are useful to break up the text; they also help to organize the main points of the article.

• Conclusion

Should summarize the article, identify gaps in knowledge and suggest recommendations for future practice.

Please send a hard copy printed on one-side only on A4 paper, double-spaced with wide margins. Please type in upper and lower case – don't use 'all capitals' anywhere. Don't forget to keep a spare copy. Also, a copy of the article should be sent on a floppy disc, saved in 'Text Only' format. Clearly state on disc label: the file name and format saved.

The journal welcomes articles of interest. This could include a literature review, research project that you have been a part of, any innovations you feel would benefit our readers. Care studies are an invaluable source to practitioners, particularly when complex situations have successfully been addressed, colour photographs and tables can be included to complement the text (the client must give written permission before publication of photographs).

All manuscripts should be between 1,000 to 2,000 words. However if you wish to submit a short report then 500 words would be acceptable.

References

Please reference the manuscripts using the Harvard system. If you need further details of this, contact the editor.

Articles should be sent to the Editor:

Lynfa Edwards

Centre for Research and Implementation of
Clinical Practice

Wolfson Institute of Health Sciences

Thames Valley University

32-38 Uxbridge Road

London W5 2BS



President: Prof.C.Moffatt

This years **Leg Ulcer Forum Conference** is being held in Sheffield on Friday 23rd November and repeated in London on Friday 30th November 2001.

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Contact LUF at the address on the back page for further details

Courses • Courses • Courses • Courses

Education Courses in Wound Care

The Centre for Research and Implementation of Clinical Practice (CRICP) of which Professor Christine Moffatt is Director, is experienced in running educational programmes designed for a range of health care professionals from different settings. Details of the courses currently offered by the Centre in partnership with the Wolfson Institute of Health Sciences, Thames Valley University, are as follows:

Leg Ulcer Management

ENB N18 – Professional Development in the Management of Leg Ulcers

Course dates: 1 October 2001 – 4 January 2002

10 January – 28th March 2002
(day release held at Reading)

8 April – 28 June 2002

17 June – 6 September 2002

October, April and June courses are held at Wolfson Institute of Health Sciences, Ealing, London.

Master Class: Leg Ulceration – Complex Case Scenarios

Dates: 8 November 2001, 16 May 2002, 25 July 2002 at Wolfson Institute of Health Sciences, Ealing

28 February 2002
at Wolfson Institute of Health Sciences,
Royal Berkshire Hospital, Reading

Pressure Sores

ENB N36 – Professional Development in the Prevention and Management of Pressure Sores

Course dates: 5 November 2001 – 21 January 2002

10 June 2002 – 2 September 2002

(Both courses based at Ealing)

Master Class: Pressure Sores – Professional and Ethical Dilemmas

Dates: 11 December 2001
9 July 2002

Tissue Viability and Wound Management

ENB N49 – Tissue Viability and Wound Management

Course dates: 3 October 2001 – 19 December 2001

at Wolfson Institute of Health Sciences,
Wexham Park Hospital, Wexham Park

14 January 2002 – 8 April 2002

at Wolfson Institute of Health Sciences, Ealing

3 April 2002 – 19 June 2002

at Wolfson Institute of Health Sciences,
Royal Berkshire Hospital, Reading

24 June 2002 – 16 September 2002

at Wolfson Institute of Health Sciences, Ealing

Vascular Nursing

ENB A85 – Vascular Nursing

Dates: 25 September 2001 - 25 June 2002 at
Wolfson Institute of Health Sciences, Ealing

Wound Healing

Master Class: Wound Healing – The State of the Art

Dates: 10 October 2001

15 January 2002

10 April 2002

25 June 2002

Further details

Further details of the above courses can be obtained from:

**The Centre for Research and Implementation
of Clinical Practice**

Wolfson Institute of Health Sciences

32-38 Uxbridge Road

London W5 2BS

Tel: 020 8280 5020



President: Prof.C.Moffatt

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•

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