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Published

2014

Journal Title

Australian Family Physician

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Stephen A Margolis

Chronic leg wounds and ulceration: an ongoing challenge

‘To be frank with you, which you must keep to yourself, a humour has fallen into our legs and our physicians advise us not to go far in the heat of the day.’¹

This famous quote is from a letter penned by King Henry VIII to the Duke of Norfolk in 1537. Henry was plagued with bilateral, purulent and seeping chronic leg wounds and ulceration, which he found particularly unpleasant and difficult to manage, and perhaps contributed to his renowned vile temper.¹

Chronic leg wounds and ulceration (CLU) have been chronicled since antiquity: the first written reference is found in the Ebers papyrus from 1550 BCE.² Interestingly, management of CLU moved from treatment with cautery in Roman times, after Hippocrates noted the association between varicose veins and ulceration, to studious inactivity to allow bad humours to escape around 500 years ago, and then back to active management around 200 years or so later.

Following this strong pedigree of curiosity, concern and activity around CLU across the millennia, where do we stand today? Has clinician interest, associated research and the passage of time provided a ready solution as it has for so many other age-old conditions? Yes, we now know that venous disease is the most common cause of CLU.³ However, the overall answer seems to be no. CLU remains a substantial clinical challenge. It has a point prevalence of 0.11% and a high level of chronicity: 24% of patients' have ulcers that persist for more than 1 year and 35% for more than 5 years; 20% of patients have experienced 10 or more episodes of ulceration and 45% of patients are housebound because of related immobility.⁴

Adverse effects of CLU on quality of life continue to be documented despite ongoing advances in modern medical treatment and analgesia.⁵ The refractory nature of venous ulcers, the most common cause, together with the high costs of long-term

therapy, has made this condition a major health problem in developed countries.³

Does CLU fit the Australian criteria for chronic disease? It would seem so as this is defined as ‘an illness that is prolonged in duration, does not often resolve spontaneously, and is rarely cured completely’, and is associated with functional impairment.⁶ Although chronic diseases are recognised in Australia as leading causes of death and disability, CLU does not qualify as a priority chronic disease in Australia.⁷

Why does CLU remain such a challenge? Is it the lack of evidence-based guidelines or lack of skill? This is doubtful as studies show that the greatest challenge in general practice remains lack of time rather than lack of skill.⁸ Is it something about the intrinsic nature of ulcer disease? Perhaps not, as studies by Fife et al suggest three core logistical and administrative challenges are the key: ‘complexity, cognitive effort, and the compensation system’.⁹

However, it has been long recognised that the core element for improving outcomes in CLU is accurate diagnosis.¹⁰ To this end, in this edition of *Australian Family Physician* we publish papers by Sreedharan and Sinha¹¹ and Sussman,¹² which revisit the differential diagnosis and evidence-based management of leg ulcers. To underline the importance of correct diagnosis, the paper on tropical and exotic ulcers by Rathnayake and Sinclair¹³ considers a range of conditions not commonly seen in Australia but that occasionally need to be considered as possible alternatives. To complete our consideration of skin ulcers and wounds, the paper on laceration repair in children by Lawton and Hadj¹⁴ discusses the management of traumatic wounds.

CLU remains an ongoing challenge for general practitioners; perhaps future inclusion as a chronic disease priority will help address some of the underlying challenges.

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