## Venous Ulcer - Follow-up Visit Checklist

### Done?  History  Notes
- [ ] Assess any potential issues preventing patient from adhering to treatment plan
- [ ] Assess any pain due to compression and any local or systemic changes relative to last visit, any new medications or allergies

### Done?  Dressing Removal  Notes
- [ ] Prevent stripping of skin if dried blood or dried exudate:
  - Irrigate dressing before and while removing the dressing
  - Cut bandage one layer at a time with blunt end scissors
  - Use adhesive releaser products
- [ ] Inspect primary dressing and document quantity, odor and appearance of exudate

### Done?  Physical Examination  Notes
- [ ] Inspect for any changes in VLU relative to previous visit: Reassess characteristics of the wound
  - Margins (typically irregular)
  - Depth (typically shallow to deep)
  - Wound bed (typically granulation tissue and fibrin)
  - Exudate quantity, appearance (typically moderate to very large exudate)
  - Odor (may be malodorous)
  - Signs of infection (edema, erythema, pain, pus)
  - Measurements: length, width and depth
- [ ] Inspect for any changes in peri-wound skin:
  - Macerated
  - Dry, eczematous
  - Signs of infection
  - Inflamed
  - Denuded
- [ ] Inspect leg edema relative to previous visit

### Done?  Documentation (medical records)  Notes
- [ ] At least weekly to assess wound healing progress.
  - Number and position of ulcers on the leg
  - Wound measurements should be made for each VLU, including area, perimeter, and depth
  - Description of wound edge, peri-wound area, wound base quality, amount and type of drainage, presence of infection
  - History of debridement

### Done?  Treatment plan summary  Notes
- [ ] Goal: 30% decrease in size in the first 4 weeks of treatment with standard care
- [ ] If limb still edematous despite adequate compression:
  - Check other causes of lower extremity edema (e.g. renal, cardiac conditions, lymphedema) and address etiology
  - If erythema, new onset of pain: rule out deep venous thrombosis
- [ ] Manage pain:
  - Vague pain upon application of compression: check if dressing too tight - may apply tubular vs. elastic bandage as last layer, ensure no arterial disease component (ABPI)
  - Pain over bone upon application of compression: apply padding or cut out foam around the prominence to offload pressure caused by bandage
  - Swollen extremity, erythematous skin, new onset calf pain: rule out deep venous thrombosis
  - Painful VLU with some exudate: consider foam dressings containing ibuprofen (Grade 2C)
- [ ] Cleanse wound with a neutral, non-irritating, non-toxic, non-antimicrobial solution (e.g. sterile saline or water) with minimal trauma (Grade 2C)
- [ ] Debridement of VLU as needed (surgical, sharp, autolytic, enzymatic or other method) (Grade 1C). Consider topical anesthetic (e.g. EMLA) prior to sharp debridement
- [ ] Inspect for any changes in skin relative to previous visit:
  - Protect peri-wound skin with a skin protectant (topical barrier) if skin in contact with exudate (Grade 2C)
  - Stasis dermatitis and dry, lightly reddened, itchy, inflamed skin: consider short course of mid potency steroids (Grade 2C)
  - Dry, itching, burning skin: calamine impregnated rolled gauze wrap as first compression layer
- [ ] Apply topical dressing on VLU to keep wound bed moist and to manage excess exudate. Options below can be used (Grade 2C)
  - Heavy exudate: specially absorptive, hydrofiber or alginate dressings
  - Moderate exudate: specially absorptive, foam dressings
  - Light exudate: non-adherent dressings or hydrocolloid
  - Minimal or no exudate: non-adherent dressings, film or hydrogel
**Dressing with foul odor:** consider activated charcoal dressing, debride if needed, check for infection, increase dressing change frequency.

**Do not use antimicrobials (topic and systemic) if no signs of clinical infection (Grade 2C)**

**Consider ancillary measures to aid in VLU healing:**
- Supervised calf muscle pump exercises (Grade 2C), leg elevation (Grade 2C), good nutrition (best practice), oral pentoxifylline (Grade 1B)

**Patient education to aid in VLU healing:** importance of compression, supervised calf muscle exercise, smoking cessation and adequate nutrition.

**Adjunctive Therapy**

<table>
<thead>
<tr>
<th>Done?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If VLU does not decrease by 30% after 4 weeks of standard care, re-evaluate patient and treatment plan. Consider</td>
</tr>
<tr>
<td></td>
<td>Wound coverage: with autologous - e.g. skin grafting, flaps- or cellular and/or tissue based products (CTP) - e.g., human skin allografts, allogeneic matrix, composite matrix, acellular matrix) associated with compression</td>
</tr>
<tr>
<td></td>
<td>Negative pressure wound therapy to increase granulation prior to skin grafting (Grade 2C)</td>
</tr>
</tbody>
</table>

**Orders/Referrals**

<table>
<thead>
<tr>
<th>Done?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vascular surgeon: if duplex ultrasound results with surgical indications (incompetent superficial venis and/or perforators, deep venous reflux or proximal chronic venous obstruction/stenosis)</td>
</tr>
<tr>
<td></td>
<td>Plastic surgeon for consideration of wound coverage, if VLU does not decrease by 30% after 4 weeks of standard care</td>
</tr>
</tbody>
</table>