

VENOUS ULCERS OF THE LOWER EXTREMITIES

Dr. Petraq Mustaqe, MD. Jerina Jaho

¹ Department of Scientific Research, University of Vlora "Ismail Qemali", Albania

Corresponding author: dr.petraqmustaqe@gmail.com

Received: 2023-12-10

Accepted: 2024-01-29

Published online: 2024-02-02

Abstract

These are wounds that begin as little scratches, itches, or hemorrhages from an enlarging, convoluted rich vein. Like any wound, this one attempts to cure itself; but, because to poor circulation, edema, and the superimposition of infection, it worsens and grows larger over time, particularly in the elderly, the very sick, inactive people, smokers, allergy sufferers, diabetics, and people with certain collagen illnesses. The area where the initial skin damage occurred is usually where they are found, internally but also medially or laterally, above the medial malleolus and below the nape. In a typical organism, a wound would heal in a few days, however in the aforementioned circumstances, the wound worsens and enlarges. About 80% of the time, post-thrombotic syndrome or untreated varicose vein disease is the cause of these ulcers.

Keywords: wounds, poor circulation, edema, ulcers, venous insufficiency, etc.

INTRODUCTION

It is well known that blood rises in the veins and moves toward the heart with the assistance of the venous valves, muscle contraction, the chest's negative pressure during exhale, and the venous wall's tonicity. These components fail in many of the disorders or diseases listed above, causing the wound to worsen and grow instead of healing.

When varicose disease has long thinned the skin of the extremities, the skin is droplet brown or has become dark brown, and there is edema of the legs, every light scratch causes the ulcer to appear and increases the infection of the environment, the wound progresses quickly. Arterial diseases, high blood pressure, heart failure, renal or liver diseases, protracted tumor diseases, and jaundice undoubtedly have a negative influence on the healing of an ulcerative skin disease. Antibiotics are often thought to be the remedy, yet this is untrue. When a wound has a clear discharge, a temperature is present, or even when the material removed from the site has revealed the microorganism and the antibiogram indicates the appropriate course of action, antibiotics are useful. How can we be certain that this injury is a result of a venous ulcer?

CLINICAL SIGNS OF VENOUS LEG ULCERS



Photo 1



Photo 2



Photo 3

Edema of the legs

Enlargement and tortuosity of the legs' superficial veins

Change in skin color to light brown

Thinning of the skin throughout the body

Thickening of the skin and redness around the wound

Alignment of the legs and their relief when raising them higher than the body

Edematous excretory lesions smelly

Based on these data, combined with personal and family history, we suspect the disease in question.

We put the seal of diagnosis

Vassal color Doppler echocardiography

Ct with contrast of veins and arteries

Evaluation of the cardiac pump

Biochemical examinations

Antibiogram of the wound material but also its histology when there are suspicions of malignancy

All these help us for an adequate treatment. Therefore, adiposity and pregnancy at young ages should be taken into account.

TREATMENT OF VENOUS ULCERATIVE LESIONS

The primary cause, which is mostly venous insufficiency, is treated first without disregarding the other elements we discussed. By maintaining the legs elevated for as long as feasible, we mechanically aid in the venous emptying. Causes of these venous ulcerative lesions are:

- Venous system stimulant
- prolonged shifting of positions during pregnancy
- Maximum standing motion elimination

Bandages or elastic socks should be used when appropriate, but not always, because pressure or tightening with excessive pressure might have a detrimental effect. Special emphasis is dedicated to the healing and regeneration of the wound. Medications for the wound must be used every day, particularly in the initial days.

The wound should be cleansed, an antibiogram should be performed in cases of infection overlap, and appropriate antibiotics should be administered. Permanent Necrotomy should be avoided until granulation commences; however, granulation should be limited to the superficial layer; plastic surgery should be performed in a comfortable manner if the wound cannot be closed due to its size. Ensuring wound coverage is crucial for promoting physiological response and employing a diluted disinfectant during the initial phases. In addition, the leg should be elevated and bandaged in a region as wide as feasible, both above and below the wound, when the tightness is removed from the wound. It is advisable to prescribe a low dosage of platelet antiaggregant together with diuretics. Plastic surgery is a possibility if the wound is extensive, but we are more in favor of the standard Saphenectomy once the Saphenectomy has been performed and the signs have stabilized. Additionally, the radiofrequency under the ultrasound has shown positive values.

REFERENCES

- Smith, J.J., Brown, L., Greenhalgh, R.M., & Davies, A.H. (2002). Randomised trial of pre-operative colour duplex marking in primary varicose vein surgery: outcome is not improved. *European journal of vascular and endovascular surgery*, 23(4), 336-343.
- Solís, J.V., Ribé, L., Portero, J.L., & Rio, J. (2009). Stripping saphenectomy, CHIVA and laser ablation for the treatment of the saphenous vein insufficiency. *Ambul Surg*, 15(1), 11-4.
- Stötter, L., Schaaf, I., & Bockelbrink, A. (2006). Comparative outcomes of radiofrequency endoluminal ablation, invagination stripping, and cryostripping in the treatment of great saphenous vein insufficiency. *Phlebology*, 21(2), 60-64.
- Subramonia, S., & Lees, T. (2010). Radiofrequency ablation vs conventional surgery for varicose veins—a comparison of treatment costs in a randomised trial. *European Journal of Vascular and Endovascular Surgery*, 39(1), 104-111.
- Subramonia, S., & Lees, T. (2010). Randomized clinical trial of radiofrequency ablation or conventional high ligation and stripping for great saphenous varicose veins. *Journal of British Surgery*, 97(3), 328-336.
- Thaler, E. (2001). Compression stockings prophylaxis of emergent varicose veins in pregnancy: a prospective randomised controlled study. *Swiss medical weekly*, 131(4546), 659-662.
- Thomasset, S.C., Butt, Z., Liptrot, S., Fairbrother, B.J., & Makhdoomi, K.R. (2010). Ultrasound guided foam sclerotherapy: factors associated with outcomes and

- complications. *European Journal of Vascular and Endovascular Surgery*, 40(3), 389-392.
- Van der Heijden, F.H., & Bruyninckx, C.M. (1993). Preoperative colour-coded duplex scanning in varicose veins of the lower extremity. *The European Journal of Surgery= Acta Chirurgica*, 159(6-7), 329-333.
- Vuylsteke, M., Van den Bussche, D., Audenaert, E.A., & Lissens, P. (2006). Endovenous laser obliteration for the treatment of primary varicose veins. *Phlebology*, 21(2), 80-87.
- Wills, V., Moylan, D., & Chambers, J. (1998). The use of routine duplex scanning in the assessment of varicose veins. *Australian and New Zealand journal of surgery*, 68(1), 41-44.
- Wright, D., Gobin, J.P., Bradbury, A.W., Coleridge-Smith, P., Spoelstra, H., Berridge, D., ... & Varisolve® European Phase III Investigators Group. (2006). Varisolve® polidocanol microfoam compared with surgery or sclerotherapy in the management of varicose veins in the presence of trunk vein incompetence: European randomized controlled trial. *Phlebology*, 21(4), 180-190.
- Zubilewicz, R., Chmiel-Perzynska, I., Derkacz, M., & Schabowski, J. (2009). The women's span of knowledge about chronic venous disease. *Family medicine and Primary care Review*, 11(4), 919-921.