Madigan Army Medical Center
Referral Guidelines

Non-Infected Lower Extremity Wound

Diagnosis/Definition

- A non-infected lower extremity wound is described as any slow or non-healing wound of the distal leg or foot not due to infection.

Initial Diagnosis and Management

Lower extremity ulceration/wounds that are not responding to standard therapy as anticipated and/or complicated by one or more of the following conditions:

1. Neuropathy
2. Immunosuppressive drug therapy
3. Diabetes
4. Osteomyelitis
5. History of amputation (partial foot or partial lower extremity)
6. History of autoimmune processes (rheumatoid arthritis, scleroderma)
7. Foot deformity
8. History of neuromuscular disease processes
9. Charcot foot deformity (**see CHARCOT FOOT REFERRAL GUIDELINE**)

Acute Treatment: Follow these instructions until the wound is fully healed:

1. Order weightbearing radiographs of both feet and ankles.
2. **TREATMENT OF WOUNDS ASSOCIATED WITH LOWER LEG EDEMA:**
    1. Ensure patient follows your instructions for use of diuretics
    2. Have the patient bathe at night paying special attention to gently cleaning their toes, feet, and legs with soap and water
    3. Have the patient apply lotion to their feet and legs but NOT between toes
    4. Have the patient then go straight to bed
    5. Upon 1st awakening in the morning the patient must apply their compression stockings [Provide patient a prescription and they can have this filled in Vascular Surgery] and get dressed including wearing supportive shoes which should be on all day
    6. If stockings are “tight”, the patient should elevate their legs so that their toes are at eye-ball level for 20 minutes and limit time spent with feet hanging down like when sitting in a chair, eating, or riding in the car
    7. Role of stockings is to limit swelling NOT squeeze it out so they must be applied upon 1st awakening as above
    8. Repeat this process daily for life
3. **TREATMENT OF NON-INFECTED FOOT, ANKLE, AND LEG WOUNDS:**
    1. Have the patient bathe at night INCLUDING cleansing the sore with soap and water
    2. Have the patient apply a thin layer of the antibiotic cream [Recommend Silvadene Cream or Bactroban Cream] to the sore with a clean Q-tip and cover the sore with a bandaide or light dressing once a day until healed
    3. Have the patient limit their standing and walking to only essentials such as to the bathroom, kitchen, or bedroom until healed

4. Have the patient elevate their legs so that their toes are at eye-ball level throughout the day and limit time spent with feet hanging down like when sitting in a chair, eating, or riding in car until told to return to normal activities by your doctor
5. Dispense a surgical shoe with an Orthopedic Work Request card to the Orthotic Lab
6. Dispense crutches with an Orthopedic Work Request card to the Cast Room.
7. The patient should be instructed to watch for signs of infection such as redness, increased pain, smelly drainage, and fever and to return or go to the emergency room for evaluation

Ongoing Management and Objectives

- To decrease the rate of toe, foot and lower extremity amputation with prompt referral of wounds that have failed to resolve with standard therapy as described above.
- To manage each patient's condition with a combination of mechanical, medical and surgical therapies tailored specifically for the unique characteristics of the wound being treated

Indications for Specialty Care Referral

- All patients with non-healing lower extremity wounds not responding to standard therapy and/or complicated by significant morbidity should be referred for evaluation to the Limb Preservation Service/Wound Care Clinic. The patient will require an approved consult to be seen.
- Venous stasis wounds should be referred to the OUTPATIENT WOUND CARE CLINIC

Criteria for Return to Primary Care

- All patients should be followed by the primary care provider for treatment of all co-morbid conditions and routine care with the goal of optimal health and wellness for the whole patient.

References

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4. Albert S. Cost-effective management of recalcitrant diabetic foot ulcerations. *Clin Podiatr Med Surg*. 2002;19:483-491.
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Last Review for this Guideline: **July 2012**
Referral Guidelines require review every three years.

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