Kliiniline küsimus nr 19

Kas kroonilise venoosse haavandiga patsiendi ravitulemuse parandamiseks tuleb erialaspetsialistile edasisuunamine otsustada kindlate kriteeriumite alusel vs mitte?
- haavandi paranemise dünaamika (kroonilise haavandi mitteparanemine)
- ravi kestus

Kriitilised tulemusnäitajad: ravisoostumus, ravi tulemuslikkus, haavandi paranemine, patsiendi elukvaliteet, patsiendi rahulolu, hospitaliseerimine, elulemus, üldsuremuse vähenemine

Süstemaatilised ülevaated, muud uuringud.

Süstemaatilisi ülevaateid ei leidunud.
Läbilõikeuuringus, kus selgitati Austraalia esmatasandil töötavate õdede praktikat ravijuhendite järgimise osas (sealjuures patsiendi edasi suunamise otsustamine), leiti, et patsiente suunati spetsiaalsetesse haavakliinikutesse põhjustel nagu krooniline haavand ei parane või haavandi seisund halveneb, vajalik on erialaspetsialisti konsultatsioon, patsiendil esinesid kaasuvad haigused. Lisaks põhjusetks võisis olla ajapuudus, oskuste ja kogemuste puudumine, kindla raviprotokolli puudumine kroonilise haavandi raviks. Samaaegselt spetsiaalsesse haavakliinikusse suunamisel olid takistusteks kaugus, pikad ooteajad, patsiendi soovimatus edasisuunamise suhtes. Artikli autorid jõudsid järeldusele, et patsiendi edasisuunamise osas peaksid olema kehtestatud kindlad kriteeriumid ja juhised. (Weller & Evans 2012).

Viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	**Viide kirjandusallikale**
Background Venous leg ulcers represent the most common chronic wound problem seen in general practice and are commonly managed by practice nurses. Compression therapy has been shown to improve healing. **Methods.** We explored current practice nurse management of venous leg ulcers to determine if evidence based guidelines were used to aid management. A cross-sectional survey in a metropolitan general practice network was used. **Results.** The majority of practice nurses reported that they do not routinely use, or have confidence in using, a Doppler to measure ankle brachial pressure index before compression application and are not responsible for application of compression therapy. Most common referrals are to wound clinics or vascular surgeons. Barriers to referral include access to services and cost of compression bandages. **Conclusion.** Our study highlights that practice nurse knowledge of venous leg ulcer management is suboptimal and that current practice does not comply with evidence	Weller, C & Evans, S (2012). Venous leg ulcer management in general practice. Australian Family Physician Vol. 41, No. 5, May

based management *guidelines.*	

Ravijuhendid

Kokkuvõte ravijuhendites leiduvast.

SIGN 2010 ekspertarvamus: **Patients who have the following features should be referred to the appropriate specialist at an early stage of management:**

- **suspicion of malignancy**
- **peripheral arterial disease** *(ABPI <0.8)*
- **diabetes mellitus**
- **rheumatoid arthritis/vasculitis**
- **atypical distribution of ulcers**
- **suspected contact dermatitis or dermatitis resistant to topical steroids**
- **non-healing ulcer.**

AWMA 2011 ekspertarvamus:

Possible indicators for specialist referral include:

- diagnostic uncertainty
- atypical ulcer characteristics or location
- suspicion of malignancy
- treatment of underlying conditions including diabetes, rheumatoid arthritis and vasculitis
- peripheral arterial disease indicated by an ABPI less than 0.833, ABPI above 1.234
- contact dermatitis
- ulcers that have not healed within three months
- recurring ulceration
- healed ulcers with a view to venous surgery
- antibiotic-resistant infected ulcers
- ulcers causing uncontrolled pain.

Practice points

- Early referral to specialists and/or a leg ulcer clinic can help ensure appropriate management.
- Patients presenting with a traumatic injury and history of venous disease should be referred to a local leg ulcer specialist service or leg ulcer clinic as soon as possible.
- In locations where specialist services are not readily available (for example, rural or remote areas) consultation could be made with a specialist using telecommunication services. One study indicated that advice from a specialist could be effectively

implemented at a local level using digital images of the ulcer.48 However, this is not to be considered a replacement for specialist review.

- Offer investigations of venous disease in patients with healed VLUs and no previous diagnosis.

SVS 2014 ei käsitle spetsialistile saatmist.

RNAO

A Specialist medical referral may be appropriate for:

- treatment of underlying medical problems
- ulcers of non-venous etiology (rheumatoid; diabetic; arterial; mixed etiology)
- suspected malignancy
- diagnostic uncertainty
- reduced ABPI (e.g., <0.8 – routine vascular referral; 0.5 – urgent vascular referral)
- increased ABPI (> 1.2 as in calcification of vessels)
- rapid deterioration of ulcers
- newly diagnosed diabetes mellitus
- signs of contact dermatitis (spreading eczema; increased itch)
- cellulitis
- consideration for venous surgery
- ulcers which have received adequate treatment, and have not improved for three months
- recurring ulceration
- ischemic foot
- infected foot
- pain management (LOE = C – RCN, 1998; RNAO Consensus Panel, 2004)
- clients with suspected sensitivity reactions (should be referred to a dermatologist for patchtesting). Following patch testing, identified allergens must be avoided and medical advice on treatment should be sought (RCN, 1998)
- a non-healing or atypical leg ulcer which should be considered for biopsy (CREST, 1998

(chronic[All Fields] AND "varicose ulcer"[MeSH Terms]) AND (("specialization"[MeSH Terms] OR "specialization"[All Fields] OR "specialist"[All Fields]) AND ("referral and consultation"[MeSH Terms] OR ("referral"[All Fields] AND "consultation"[All Fields]) OR "referral and consultation"[All Fields] OR "consultation"[All Fields]))
Leitud üks allikas.