**Assessment, Diagnosis and Referral Pathway for Patients with Lower Leg Ulcers**

The rule of three Is, ADP and PPL

**INFECTION**
- At least two systemic symptoms of infection (fever, tachycardia, malaise, headache, muscle pain)?
- Signs of necrotizing fasciitis such as strong pain, rapidly evolving redness and swelling, crepitation or hemorrhagic bullae?
- Several signs of clinical infection? Redness or discoloration in dark skin, heat, swelling, pain, purulent exudate or are the infection parameters (blood results) raised?
- Remember result of the bacterial swab alone is NOT a sign of infection

**ISCHEMIA**
- General symptoms (walking related pain, increased wound pain when elevated legs, resting pain)
- Arterial insufficiency (no palpable pulses/or ABI <0.6)
- Major ABI pitfalls: If ABI >1.4, suspect medial calcification

**ATYPICAL SIGNS**
- Unexpected severe pain, atypical location and appearance, violaceous wound borders, excessive overgranulation, no treatment response within 4 weeks
- Refer the patient to or consult a dermatologist or a wound specialist

**DISTENSION AND OEDEMA (VENOUS INSUFFICIENCY OR LEG OEDema)**
- Refer the patient to or consult a dermatologist or a wound specialist
- Start compression therapy if no contraindications (chapter 8) and consider referring the patient to vascular surgeon or phlebologist
- Assess other reasons for oedema (see chapter 5)
- If leg oedema, measure the circumference of the ankle and calf to monitor the effect of compression therapy

**PRESSURE INJURY**
- Perform pulse palpation (exclude arterial disease), monofilament test and examine shoes (exclude neuropathy)
- Start off-loading and pressure relief

**LOCAL TREATMENT**
- Consider compression therapy, conventional dressings and if needed, consider advanced therapy including surgical procedures

**INFECTION**
- Consider sending the patient to emergency
- Send the patient to emergency
- Follow the local guidelines of treating wound infection

**ISCHEMIA**
- Arterial assessment
- Refer patient to vascular surgeon

**INSULIN = DIABETES MELLITUS**
- Diabetes and ulcer in the ankle, foot, or toe region?
- Diabetes and ulcer in the gaiter region?
- If no diabetes
- Consider monitoring the glucose profile and identifying potential risk factors for diabetes

**ATYPICAL SIGNS**
- Refer the patient to or consult a dermatologist or a wound specialist

**DISTENSION AND OEDema**
- Refer to or consult a dermatologist or a wound specialist

**PATIENT REPORTED OUTCOMES**
- Assess and treat according to patient-centred care principles: Quality of life, nutrition, pain, other lifestyle factors, comorbidities, social and psychological factors and capability of self-care

**IS THE PERRIWOUND SKIN AFFECTED?**
- Assess for maceration, erosion, eczema, erythema, oedema, blister formation, lipodermatosclerosis and hyperkeratosis
- Consider optimizing dressings, barrier products and topical corticosteroids in combination with compression therapy if no contraindications

**LOCAL TREATMENT**
- Consider compression therapy, conventional dressings and if needed, consider advanced therapy including surgical procedures

**The EWMA Lower Leg Ulcer Diagnosis & Principles of Treatment document is supported by Essity, Hartmann and URGO**

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**References:**
- This guide is published as part of the EWMA document: Isoherranen K, Montero EC, Atkin L, Coller M, Hagh A, Ivory JD, Kirketerp-Møller K, Meaume S, Ryan H, Stuermer EK, Tijssen GS, Probst S. Lower Leg Ulcer Diagnosis & Principles of Treatment. Including Recommendations for Comprehensive Assessment and Referral Pathways. J Wound Management, 2023(1 Sup2):