LEG ULCER: A CHALLENGING CONDITION
ÚLCERA EN LA PIERNA: UNA CONDICIÓN DESAFIANTE

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Abstract

Lower limb, pressure and neoplastic ulcers can be complications of circulatory, neurological and metabolic disorders of aging. Health care must assess the quality and not only the quantity of life of these patients. Therefore, non-specialist professionals need to obtain adequate prior training to deal with these injuries. The aim of these comments is to emphasize the training of primary health care workers on the diagnosis and management of leg ulcers in low- and medium-income countries. Herein are included a very recent Ecuadorian and two previous Brazilian manuscripts. The main factors related to etiology, management and prognosis are commented on.

Resumen

Úlceras en miembros inferiores, por presión y neoplásicas pueden ser complicaciones de alteraciones circulatorias, neurológicas y metabólicas del envejecimiento. La asistencia sanitaria debe valorar la calidad y no solo la cantidad de vida de estos pacientes. Por lo tanto, los profesionales no especialistas deben obtener una formación previa adecuada para hacer frente a estas lesiones. El objetivo de estos comentarios es enfatizar la formación de los trabajadores de la atención primaria de salud en el diagnóstico y tratamiento de las úlceras de las piernas en los países de ingresos bajos y medios. Aquí se incluyen un manuscrito ecuatoriano muy reciente y dos brasileños anteriores. Se comentan los principales factores relacionados con la etiología, el manejo y el pronóstico.

Dear Editor:
Ulcers affecting the lower limbs constitute a frequent cause of outpatient attention in primary care settings mainly in individuals with comorbidities, and these patients are more often evaluated and managed by non-specialized professionals. [1,2] Malignancies may develop at the site of burn scars and non-healing chronic ulcers, and late diagnosis or misdiagnosis can propitiate the occurrence of severe outcomes. [2]

Rosero Arboleda and Loor Zambrano commented on the role of primary care for lower limb ulcers, involving possible diagnostic failures and lack of specialized care [1]. They reported an 86 year-old woman with hypertension, diabetes type 2, and a healed wound of the right leg, which after local trauma evolved as an irregular, painful ulcer without signs of infection. The lesion was managed by a family doctor in a primary care office, and also a vascular surgeon through telemedicine, with the healing in 9 months. The authors focused on comorbidities, longstanding course, and the 30% of recidivism in this condition, which includes venous, arterial, neuropathic, and malignant causes; besides the importance of early signs of infection and unidentified foreign body [1]. They accented the need for individualized management of these ulcers by debridement, irrigation, dressings, bandages, alginate, hydrocolloid, corticosteroids, antimicrobials, analgesics, flavonoids, troxerutin, glycosaminoglycans, and pentoxifylline, and control of

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management in two or four weeks [1]. They concluded that more specific training of primary care workers is necessary to promptly and adequately control leg ulcers.

In this setting, two previous Brazilian case studies might be of some interest. [2,3] A Marjolin's ulcer due to a squamous cell carcinoma was described in a 73-year-old woman with a traumatic leg ulcer, and the malignancy evolved unsuspected on the lesion border in association with local venous insufficiency and lymph edema. [2] She presented hypertension, diabetes type 2, congestive heart failure, and a non-healing infected vegetating lesion on her left leg. Thirty-five years before admission, she had an ulcer developed due to trauma over a site of chronic venous insufficiency. Worthy of note, the average time for malignant changes in chronic Marjolin's ulcer is 35 years, differing of the acute type that develops in less than one year. [2] Differential diagnoses included pseudoepitheliomatous hyperplasia, basal cell carcinoma, melanoma, sarcoma, hanseniasis, leishmaniasis, mycosis, syphilis, tuberculosis, and mycobacteriosis [2] The authors highlighted the very aggressive behavior of this malignant cutaneous tumor, the role of adequate management of primary ulcers, the ominous late diagnosis, and the enhancing of suspicion index of primary care workers about this challenging entity. [2] Before the surgical procedure and postoperatively, the patient was treated by the dermatology team, and the leg lesions were solved in approximately 1 month.

Another report was a 65-year-old woman with chronic seropositive rheumatoid arthritis (RA) and pulmonary cavity who had a non-healing cutaneous ulcer in the left elbow. [3] Subcutaneous nodules of RA often occur in pressure sites of extremities giving origin to ulcers as a result of central necrosis of the nodules due to vasculitis of small vessels. [3,4] Worthy of note in the present case study was the high level of anti-cyclic citrullinated peptide, which is related to extra-articular manifestations of RA, including nodules. [3] Worthy of note, under the specialized care of a dermatologist, the elbow ulcer was cured in 3 weeks.

Cutaneous ulcers occasionally encompass management challenges; in special the chronic lesions that pose variable difficulties for medical control in primary care sceneries; besides significant burdensome socioeconomic effects and the worst health-related quality of life of the aged population, mainly women. [1-5]

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