

# NHS Greater Glasgow & Clyde Compression Therapy Formulary: Hosiery and Bandages Guidance November 2019

## Primary Care and Acute Joint Formulary

**The emphasis of this formulary is on the use of hosiery kits as first line management of simple venous leg ulcers.**

**Compression bandages will continue to be used for the management of complex venous leg ulcers & chronic oedema.**

<b>Date of publication:</b>	November 2019
<b>Review date:</b>	November 2021
<b>Lead Author:</b>	Tricia McShane
<b>Approval Group:</b>	Area Drugs & Therapeutics Committee
<b>Changes to clinical content of this version:</b>	<b>No changes to product choices; costs, membership and references updated</b>
<b>Version no.</b>	2

## **Foreword**

This formulary has been developed as a guide to aid Healthcare Professionals (HCP) in selecting the most appropriate products to use in practice for patients, with chronic venous insufficiency (CVI), who requires management of chronic oedema and/or active venous leg ulceration.

It is estimated that patients with diagnosed venous leg ulcers account for 1:170 adults in the UK. (Guest 2015). This does not take into account those in the population who have not been diagnosed and are at risk of ulceration or in remission (healed ulcers/controlled chronic oedema).

CVI is a life-long chronic condition with a significant impact on quality of life as well as considerable impact on health care resources. The cost of prescribing compression bandages and hosiery in NHSScotland is £4m per annum. It is therefore essential that resources are used safely and cost effectively for the benefit of patients.

Compression therapy remains the gold standard in the management of CVI. Ashby et al 2014 demonstrated that for those patients with simple CVI and venous leg ulceration, hosiery kits are as effective in achieving therapeutic levels of compression compared to bandages; and can support self management by the patient (and carer). For this reason the hosiery kits will be considered first line management for simple venous ulceration with the use of compression bandaging for the complex stages of venous ulcers and chronic oedema.

This formulary can support HCP to identifying learning needs for professional development to deliver best practice.

Products are all included on Scottish Drug Tariff. Links: [Part two](#) & [Part four](#)

Further information:

Vascular home page: [Available HERE](#)

NHSGGC prescribing therapeutic formularies: [Available HERE](#)

The following hosiery and bandage choices are suitable for the management of the **majority** of patients with chronic venous insufficiency and venous leg ulcers. For variances refer to following page.

<b>HOSIERY CORE PREFERRED CHOICES:</b>			
<b>Aim: prevention of leg ulceration and management of chronic oedema.</b>			
<b>Suitable for patients in remission to prevent venous leg ulcer recurrence.</b>			
<b>All hosiery choices are latex free</b>			
Cost per pair unless otherwise stated	Unit size	Length	
<b>Category 1: British Standard Short Stretch Hosiery</b>			
<b>Suitable for prevention of leg ulcers in absence of chronic oedema</b>			
(P) Duomed Soft <sup>®</sup> (Mediven) (Sand coloured)	S, M, L, XL, XXL Class 1 (14-17 mmHg) Class 2 (18-24 mmHg) Class 3 (25-35 mmHg)	<b>£7.58</b>	Available in below knee and thigh length options
<b>Category 2: European/RAL Standard Hosiery: Circular Knit</b>			
<b>Suitable in presence of oedema/lymphoedema</b>			
(P) Mediven Plus <sup>®</sup> (Mediven)	Sizes I-VII Stock option Class 1 (18-21 mmHg) Class 2 (23-32 mmHg) Class 3 (34-46 mmHg)	<b>£28.53 - £31.83</b>	Available in petite, standard and wide calf options
(P) Mediven Active <sup>®</sup> (Mediven)			
(P) Mediven Elegance <sup>®</sup> (Mediven)			
(T) Altiven <sup>®</sup> (Altimed Ltd)	Made to measure option only Class 1 (18-21 mmHg) Class 2 (23-32 mmHg) Class 3 (34-46 mmHg)	<b>£21.78</b>	
<b>Category 3: Hosiery Kit: British Standard.</b>			
<b>Suitable to treat "Simple" venous leg ulcers, in absence of oedema. Contain two liners and compression stocking</b>			
(P) Altipress 40 <sup>®</sup> (Altimed Ltd) Kit	S, M, L, XL, XXL kit	<b>£14.50</b>	short, regular, long options
<b>Category 4: Hosiery KIT: European Standard</b>			
<b>Suitable to treat "Simple" leg ulcers and oedema and misshapen limb</b>			
Actilymph <sup>®</sup> (Lohmann & Rauscher (L&R))	40mmHg kit	<b>£29.97</b>	Standard length only
<b>COMPRESSION BANDAGES CORE PREFERRED CHOICES:</b>			
<b>Aim: prevention and management of leg ulceration and uncontrolled chronic oedema, in misshapen limbs, when hosiery not appropriate.</b>			
<b>All options are latex free * contains latex within bandage, with minimal risk of direct contact with skin.</b>			
<b>Category 1: Short Stretch Inelastic Bandages</b>			
<b>Suitable for management of chronic oedema and treatment for venous leg ulcer Provides 40mmHg at ankle</b>			
(P) Actico <sup>®</sup> (L & R) cohesive bandage* (requires Ksoft liner)	10cm x 6m	<b>£3.38</b>	12cm x 6m <b>£3.34</b>
(T) Actico 2C Kit (L & R) short stretch inelastic -no liner required	10cm x 6m	<b>£8.03</b>	10cm x 6m and 10cm x 9m <b>£9.04</b>
<b>Category 2: Multi-layer Elastic/Inelastic Kits</b>			
<b>Aim: Management of chronic oedema and treatment for venous leg ulcer</b>			
<b>Provides 40mmHg at the ankle</b>			
(P) Coban2 <sup>®</sup> (3M) cohesive kit** (includes comfort layer bandage)	10cm x 6m	<b>£8.24</b>	
<b>Bandage Category 3 :Two-layer reduced Elastic/Inelastic Bandage Kits*</b>			
<b>Provides 20mmHg at the ankle</b>			
<b>Suitable for patients who cannot tolerate full compression due to pain or underlying aetiology</b>			
(T) Coban2 Lite <sup>®</sup> (3M)** includes comfort layer bandage	10cm x 6m	<b>£8.24</b>	

## VARIANCES for patients with complex needs

<b>HOSIERY VARIANCES</b>		
<b>Category 1: British Standard Hosiery Kit Liner Packs. Each liner provides 10mmHg at the ankle. Supplied in packs of three.</b>		
<b>Altipress (Altimed Ltd) sizes S,M,L,XL,XXL Pack of 3 liners Available in Short, Regular and Long Lengths</b>		<b>£11.46 per pack</b>
<p>Aim: to provide reduced compression in following circumstances:</p> <ol style="list-style-type: none"> <li>1. One liner can be used to deliver 10mmHg for patients who are waiting for full assessment and ABPI Doppler to exclude arterial disease</li> <li>2. Patients who cannot tolerate compression due to pain or other issues</li> <li>3. Patients who are unable to tolerate compression but may have liner layers added over time to build up compression to therapeutic levels</li> </ol> <p>Exclusion: Do not use with patients who have gross oedema, diabetes, signs of ischaemia or in your clinical judgement are not suitable.</p>		
<b>MADE TO MEASURE CUSTOMISED HOSIERY</b>		
Aim: to provide therapeutic levels of compression for patients with misshapen, oedematous limbs whose measurements <b>Do not</b> conform to standard hosiery.		
<b>Unit size.</b>	<b>Length</b>	
<b>Category 3: European/RAL Standard Hosiery: Flat Knit Class 1 – 3. Suitable in presence of oedema/lymphoedema and misshapen limb</b>		
(T) Mediven Mondri® (Mediven) Latex free	Class 1 (18-21mmHg) Class 2 (23 -32mmHg) Class 3 (34-46mmHg)	<b>£33.92</b> <b>£35.52</b> <b>£39.80</b>
Jobst Elvarex Custom® (BSN Medical) Contains latex	Class 1(18-21mmHg) Class 2: (23-32mmHg) Class 3: (34-46mmHg)	<b>£33.05</b> <b>£36.70</b> <b>£39.98</b>
Jobst Elvarex Soft Custom® (BSN Medical) Latex free	Class 1(18-21mmHg) Class 2: (23-32mmHg) Class 3: (34-46mmHg)	<b>£22.80</b> <b>£35.98</b> <b>£38.45</b>
<b>BANDAGE VARIANCES</b>		
<b>Multi- layer 1: Sub compression wadding suitable for skin contact layer to protect skin and shape – suitable for patients who are awaiting pre assessment including Doppler</b>		
(P) KSoft® (Urgo)	10cm x 3.5 m 10 x 4.5	<b>£0.46</b>
<b>Multi- layer 2: Light support bandage (Type 2) suitable for use pre ABPI or for patients who do not tolerate compression.</b>		
(P)KLite® (Urgo)	10cm x 3.5 m	<b>£1.02</b>
<b>REDUCED COMPRESSION BANDAGE suitable for patients with mixed aetiology ulcers</b>		
<b>(T) Potential variance:</b>		
Class 3A and 3B may be a recommendation from acute vascular to provide reduced compression in management of at risk limb or mixed aetiology ulcer patient group:		
• 3A- spiral equates with 13 mmHg - Profore 3 (S&N)		<b>£3.92</b>
• 3A figure of 8 equates with 17 mmHg Profore 3 (S&N)		<b>£3.92</b>
• 3B in spiral equates with 23 mmHg Profore 4 (S&N)		<b>£3.67</b>
Discuss with Healthcare Professional initiating therapy or relevant clinical nurse specialist to ensure safe effective patient care		

<b>MEDICATED BANDAGES</b>		
Suitable for patients with dermatological skin conditions:		
<b>Paste Bandages</b>		
Ichthopaste® (Smith and Nephew) Zinc oxide paste and ichthammol bandage	7.5 cm x 6m	<b>£3.74</b>
Viscopaste (Smith and Nephew)cotton fabric medicated bandage with zinc oxide	7.5 cm x 6m	<b>£3.78</b>
Zip Zoc® (Smith and Nephew)	14 x 82 cm	<b>£3.47</b>

<b>ACCESSORIES</b>		
<b>Hosiery Application Aid : suitable for patients with poor dexterity</b>		
Actiglide® (Activa)	one size	<b>£14.62</b>
Foot Butler		<b>£8.00</b>

<b>Waterproof protector to allow showering without removal of compression bandages</b>		
Seal Tight® - (Autono-Med Ltd) Adult (Knee length)	Short length Wide short leg	<b>£10.50</b>

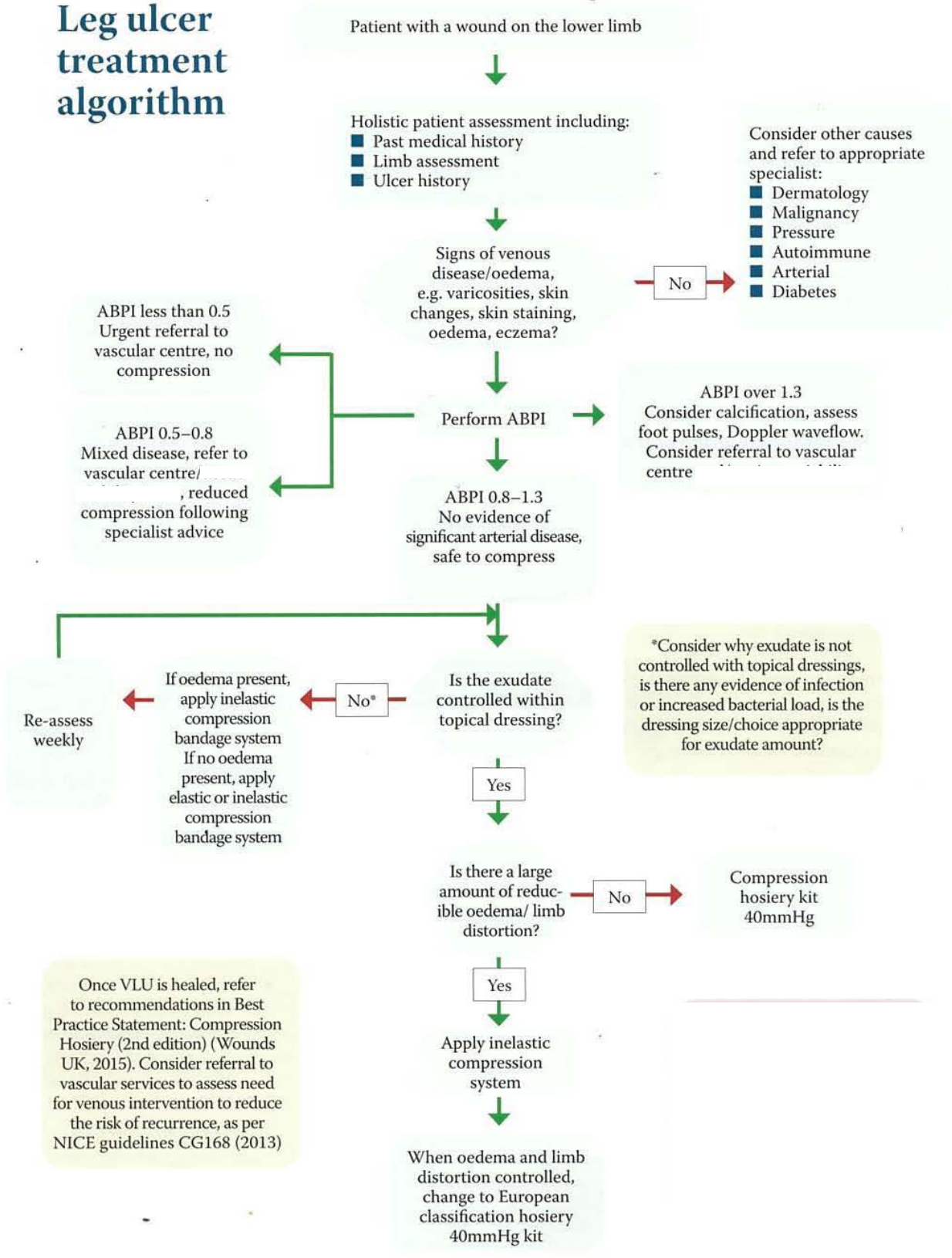
## **EXCLUSION CRITERIA**

To be used in conjunction with clinical judgment

- Arterial disease (ischaemia) according to vascular assessment
- Current acute inflammatory episode
- Acute deep vein thrombosis
- Patients with diabetes or rheumatoid arthritis unless after specialist referral and under supervision, due to risk of microvascular disease
- Uncontrolled congestive heart failure, as compression could lead to cardiac overload
- Sensory disorders of the limb i.e. peripheral neuropathy unless after specialist advice (caution)
- Known sensitivity to the fabric

Leg Ulcer Treatment Algorithm© courtesy of Atkins and Tickle, with permission provided to produce with minor amendments.

# Leg ulcer treatment algorithm



## **1. ACCOUNTABILITY AND RESPONSIBILITY/SCOPE OF PRACTICE**

It is important to “**Define what good practice looks like** and **address variations** against it, standardising care processes where appropriate” (Kings Fund, 2015).

Compression therapy is the gold standard for prevention and treatment of chronic venous insufficiency and venous leg ulcers. **Hosiery Kits** are considered first line management for Simple Venous Leg Ulcers.

Compression bandages will continue to be used for complex leg ulcers and management of chronic oedema.

Compression therapy should only be applied by those HCPs competent to do so, providing the most appropriate treatment which will deliver safe, effective, efficient, equitable and timely person centred care. HCPs that prescribe, or are influencing prescribing decisions on choice of products, should ensure that reasonable volumes are prescribed to reduce waste, minimise variations in practice and promote best practice. This should also facilitate positive patient engagement.

HCPs should ensure that competencies, in the management of patients with CVI and non medical prescribing are included in their PDP.

Patients who are managed with compression therapy (hosiery and bandages) should have regular ongoing assessment to ensure arterial status has not worsened. Reassessment should take place around 3, 6 or 12 monthly intervals dependent on initial and ongoing therapy outcomes. (NICE 2013)

To ensure clear and comprehensive management plan assessment and ongoing care should be documented in NHS GGC CNIS and ICP leg ulcer pathway.

If there is absence of ulcer progression or signs of deterioration; vascular or specialist intervention may be considered appropriate.

Detailed discussion on the aetiology and pathophysiology of CVI is out with the scope of this Formulary. However, some general guidance has been provided on assessment of patient to support best practice, Refer to bibliography at the end and link to vascular and leg ulcer services

Available [HERE](#)

## **2. PATIENT ASSESSMENT**

**Prior to initiation of compression therapy a full holistic assessment must be undertaken. Including ABPI Doppler.**

“There is now strong evidence which shows that where individual patients are actively involved in their care, outcomes improve” (DoH, 2011)

- Process summarised in Leg Ulcer Treatment Algorithm
- Differentiate if venous ulcer is “Simple” or “Complex (Table One)
- Venous leg ulcers and chronic oedema have a significant impact on patients’ quality of life and mutually beneficial partnerships between patients, their families and those delivering care will support positive patient outcomes. (Table Two).
- Take into account comorbidity and ulcer related factors which may be barriers to healing (Table Three)

**Table One: Differentiate if venous ulcer is “Simple” or “Complex”**

Nb this is not an exhaustive list and should be used as a guide together with clinical judgment

“Simple” venous leg ulcer	“Complex” venous leg ulcers
ABPI 0.8-1.3	ABPI outside of 0.8 – 1.3 range
Area <100cm <sup>2</sup>	Area greater than 100cm <sup>2</sup>
Present for less than 6 months	Present for greater than 6 months
	Co morbidities e.g. diabetes, renal, rheumatoid disease
	Cardiac failure (controlled or uncontrolled)
	Current infection/history or recurrent infections
	Wound has failed to reduce in size by 20-30% at 4-6 weeks
	Fixed ankle or reduced range of motion
	Foot deformity
	Unmanaged pain
	History of non engagement with treatment

**Table Two: Expectations and promoting patient centred engagement**

Assessment : inform the patient that:
A full leg ulcer assessment will be carried out including investigation of ABPI to confirm if compression treatment is appropriate.
Routine swabbing of leg ulcers is not recommended
They should make known if they are aware of any allergies, to inform treatment option
Treatment
To optimise patient engagement
Compression therapy is the single most important treatment for a leg ulcer and management of CVI, resolution of chronic oedema and healing ulcers is the aim of the treatment; thereafter the patient will be in remission and to prevent ulcer recurrence and control oedema, which will require lifelong use of hosiery and patient commitment
Discuss with patient that a hosiery kit is the first line treatment for non complex situations and bandages will only be used during complex management phase; thereafter hosiery kits will be considered. If required application aids can be considered for those patients with poor dexterity who find hosiery difficult to apply
Explain that self management with hosiery kit will involve removal of top layer overnight and replace again in morning. For showering purposes all layers can be removed and reapplied.
If bandages are used seal tight covers may be used to allow showering between bandage changes
Compression bandages require at least weekly changes unless condition dictates otherwise. Wound dressings should be simple contact layer which protect ulcer under hosiery kit or bandages
Oral antibiotics are only needed very occasionally e.g. Spreading cellulitis, infection.
Further investigation
Discuss the following with the patient:
Pain scores and analgesia as indicated
If condition fails to progress, specialist referral (i.e. vascular or dermatology) may be indicated
Ongoing and regular holistic reassessment is required. ABPI may be repeated if ulcer fails to progress after 12 weeks of compression therapy.
Discuss with the patient the importance of self care
Exercise
Regular ankle/calf exercises
Elevation of legs at rest
Exploring sleeping pattern and encourage bed rest at night
Importance of hydration and healthy diet
Maintaining skin hydration using simple emollients e.g. Zerobase,50:50
Skin should be washed with potable water to remove emollient prior to further application. Debridement wipes/pads should not be used for social hygiene to remove build up of emollients. Use is for wound bed debridement and hyperkeratosis exfoliation
Provide patient with patient information leaflet or direct to relevant patient self help sites



**Table Three: comorbidity and ulcer related factors which may be barriers to healing**

Nb this is not an exhaustive list and should be used as a guide together with clinical judgment

Checklist for leg assessment	TIMES checklist for venous ulcer assessment
<p><u>Limb related factors:</u></p> <ul style="list-style-type: none"> <li>• Presence and distribution of oedema; (oedema is likely to become non-pitting with chronicity due to development of fibrotic tissue)</li> <li>• Limb size and shape (reduction in loss of calf muscle, misshapen limb)</li> <li>• Mobility and/or ankle movement (reduces venous return and increases risk of chronic oedema and development of signs of venous insufficiency)</li> </ul>	<p><b>Tissue</b> -non viable or deficient – assess tissue quality, slough and any necrosis (necrotic tissue is not expected with simple VLU). Compression therapy should promote improved perfusion at wound bed and resolution of moist slough.</p> <p><b>Infection or inflammation</b> – colonisation is common in VLUs; the longer a wound is in existence the greater the likelihood of biofilm production. Compression therapy will improve venous return, reduce risk of biofilm formation and need for topical antimicrobial dressings.</p> <p><b>Moisture imbalance</b> – any exudate should be assessed in terms of colour and viscosity as well as volume (greater viscosity and discolouration greater chance of biofilm or chronicity factors). Excess exudate due to CVI should be improved with compression therapy</p>
<p><u>Vascular related factors:</u></p> <ul style="list-style-type: none"> <li>• Vascular history</li> <li>• Signs of arterial insufficiency</li> <li>• Erythaema, pallor and/or cyanosis, reduced skin temperature</li> <li>• Signs of venous insufficiency - e.g. oedema, ankle flare, hyperpigmentation, lipodermatosclerosis, atrophe blanche, varicose eczema</li> </ul>	<p><b>Edge of wound</b> – assess for signs of overgranulation due to increased moisture at wound bed which should improve with compression therapy, encrusted debris, should improve with skin hygiene.</p> <p>Rolled edges and possible malignancy require referral for specialist advice.</p> <p><b>Surrounding skin</b> – ensure patient hygiene issues are addressed.</p> <p>When venous leg ulcer present choose primary dressing which manages exudate and does not retain chronic wound fluid on surrounding skin, which can result in excoriation, moisture-associated dermatitis or odour.</p> <p>Best practice is to use a simple contact layer dressing on ulcers e.g. silicone NA or Atrauman.</p> <p>If exudate is excessive consider the addition of a low profile super absorbent dressing under compression layer e.g. Kliniderm super absorbent dressing.</p> <p><b>NB</b> additional absorbent pads/dressings, beneath compression bandages, will alter the shape of the limb and affect level of compression.</p>

### 3. ENSURING APPROPRIATE CHOICE OF HOSIERY KIT /BANDAGES

Explore and discuss with patient whether hosiery or bandages would be the most appropriate treatment option (Table four)

For those patients who are not suitable for hosiery kit and commenced on compression bandaging: Reassess on a regular basis and switch to hosiery kit once oedema and wound exudate is controlled

**Table 4: Benefits and limitations of compression bandages and hosiery**

Compression system	Benefits	Limitations
<b>Compression hosiery kit (first line treatment where possible)</b>	<ul style="list-style-type: none"> <li>• Healing rates of ulcers are comparable to compression bandages (Ashby et al, 2014)</li> <li>• Delivers known and consistent compression levels, including foot</li> <li>• Allows for patient self-care</li> <li>• Facilitates support by carer</li> <li>• Low profile, discreet</li> <li>• Allows footwear to be worn</li> <li>• General improvement in skin condition if patients can remove/reapply and carry out social hygiene</li> <li>• Can be cost effective (washable) compared to multi layered bandages</li> <li>• Reduced clinic time in terms of duration and number of visits, particularly if patient is involved in self care</li> </ul>	<ul style="list-style-type: none"> <li>• Not suitable for misshapen limb</li> <li>• Not suitable for uncontrolled oedema or rapidly decreasing limb size (may be used once oedema is controlled)</li> </ul>
<b>Compression bandages</b>	<ul style="list-style-type: none"> <li>• Conformable</li> <li>• Suitable for most limb shapes/sizes</li> <li>• Inelastic compression bandages can facilitates volume reduction/limb reshaping</li> <li>• High-stiffness systems (e.g. inelastic bandages) produce the greatest improvement in venous blood flow (Harding et al 2105)</li> <li>• Elastic component systems incorporate useful sub-bandage pressure level guides.</li> </ul>	<ul style="list-style-type: none"> <li>• Therapeutic compression levels rely on higher levels of skill to apply effectively compared to hosiery</li> <li>• Patient relies on HCP to carry out procedure</li> <li>• Does not facilitate self care</li> <li>• Can be bulky – may restrict use of footwear</li> <li>• Can feel hot and uncomfortable</li> <li>• Impact on patient quality of life with need for regular visits or clinic appointments and restriction on work/holidays etc</li> </ul>

## 4. GENERAL HOSIERY CONSIDERATIONS

The following considerations are intended to complement the NHSGGC Guide to Venous Leg Ulcer Prevention.pdf available in the vascular and leg ulcer services webpage. [HERE](#)

- All HCPs should have knowledge of different types of hosiery available and the therapeutic benefit and anticipated risk of each.
- HCPs should be able to discuss with patients the rationale for choice of flat knit, circular or custom made hosiery to support person centred care and ensure recommended treatments are achieved and maintained
- Circular knit hosiery is preferred choice when there in absence of limb distortion and in presence of mild oedema
- Flat knit (RAL) may be suitable for patients with lower limb oedema and misshapen limbs. Some patients may find these easier to apply, if dexterity is a challenge, such as rheumatoid patients or those with poor flexibility.
- Ideal time to measure for hosiery is preferably early morning, or immediately after removal of compression bandages or after a period of limb elevation, when the limb is as free of oedema as possible, to ensure an exact fit of hosiery.
- Most options are available in both open and closed toe version (patient preference)
- Hosiery should last up to 6 months or before if damage or wear is evident (two packs – one to wear, one to wash which should account for maximum of 4 pairs a year)
- British Standard Class 1 Hosiery (provided 14-17mmHg) can be bought over the counter; however patients should not be commenced in any hosiery with higher compression capabilities without full holistic assessment including ABPI

**NB.** The majority of patients will be suitable for formulary stock size hosiery.

ActiLymph® is available on formulary for misshapen limbs, with skin folds, or severe oedema/lymphoedema. If following measurement of limb, available size is not suitable, custom made to measure may be considered.

## 5. GENERAL COMPRESSION BANDAGE CONSIDERATIONS

If hosiery is not indicated and compression bandages are considered most appropriate; general factors relating to bandaging should be taken into account to help inform best practice for choice and application.

- HCPs should be able to discuss with patients the rationale for choice of bandages and when it may or may not be suitable to use hosiery
- Ensure competency in the application of compression bandages to sustain therapeutic levels of compression and prevent bandage trauma by following manufacturer's instructions
- Instruct patient and carer to be aware of any adverse effects, including causes of pain, slippage etc
- Mixed aetiology ulcers (e.g. diabetes, PVD, RA) may require specialist investigation and variances on above application technique will follow discussion with acute vascular or dermatology specialist on the most appropriate technique and bandage choice.

## 6. MEDICATED BANDAGES (REFER TO SUMMARY TABLE)

- Zinc paste bandages have been used with compression bandages for the treatment of CVI for patients with lichenification and eczema
- They provide a physical barrier to stop damage from scratching and help to break the “itch- scratch” cycle in these conditions.
- Paste bandages are associated with hypersensitivity reactions and should be used with caution
- Topical steroids action is intensified if used with paste bandages and doses should be altered accordingly
- There is a special method of application using a ‘pleat’ technique, rather than a spiral. This stops the bandage from tightening and constricting the limb as it starts to dry and allows greater freedom of movement.
- Inform patients that they should contact their HCP if bandage becomes tight.
- To ensure patient safety refer to manufacturer’s instructions prior to use.

## 7. ALLERGENS AND USE OF COMPRESSION BANDAGES

- “The incidence of contact allergy increases with the duration of ulceration”. Principal sensitisers include ingredients of topical applications, dressings and bandages. Examples include: lanolin, antibiotics, antiseptics, preservatives, emulsifiers, resins and latex. However, the majority of latex allergy incidence is associated with inhalation rather than contact.
- The guideline has taken into account such factors and where possible, minimised the risk to patients and staff in product selection and making clear identification of those containing latex.
- To minimise risk those compression bandages containing latex, have latex embedded into core of product and therefore are not in direct contact with skin; with majority of products latex free, providing alternatives for those at risk..

For further information refer to NHSGGC “Safe Use of Latex” Policy:

<http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/Health%20and%20Safety/Corporate%20Health%20and%20Safety/Documents/Policies/Latex%20Policy.pdf>

**PATIENT: If an allergy is suspected/known:** confirm diagnosis (patch test or referral to dermatology)

- treat contact dermatitis appropriately
- do not use bandages with latex (or known sensitiser)
- use bandages with high cotton content, or that have double covered yarns to limit skin contact with elastic components
- use of a cotton tubular under layer (which must be wrinkle free on application)

(Ref: edited from International consensus: Best Practice for the management of lymphoedema 2006.  
[http://www.woundinternational.com/pdf/contnet\\_175.pdf](http://www.woundinternational.com/pdf/contnet_175.pdf))

## 8. COMPRESSION THERAPY IMPLEMENTATION GROUP

Tricia McShane (chair of working group), CNS Vascular Primary Care, Member of ADTC therapeutics sub group	Barbara Kelly, Treatment Room Nurse, NE Sector
Drew Davidson, Vascular CNS, Inverclyde Royal Infirmary	Susan Maclean, Treatment Room Nurse, South Sector
Celia Macaskill, Dermatology CNS, QEUH	Lynsey O'Dwyer DN East Renfrew
Martin Fairgrieve Treatment Room Co-ordinator	Rosemary Meenan DN East Dun
Alison Duncan, Vascular Nurse Specialist, Acute Sector	Lynne Watret, Interim Non Medical Prescribing Lead NHSGGC
Margaret Fisher, District Nurse, NW Sector	Lynn Welsh, Lecturer, University West of Scotland
Linda Watson Practice Development Nurse/DN	Elaine Farrell, Tissue Viability Nurse NHS Argyle & Bute
Isobel Proctor Team Lead Orthotics	

## 9. BIBLIOGRAPHY

Suggested bibliography does not constitute an exhaustive list and it is the responsibility of the HCP to keep up to date as per NMC code of conduct (2013) <https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf>

Ashby RL et al (2014)\_VenUS IV (Venous leg Ulcer Study IV) - compression hosiery compared with compression bandaging in the treatment of venous leg ulcers: a randomised controlled trial, mixed-treatment comparison and decision-analytic model. Health Technology Assessment 18(57):1-293

Bianchi J (2013) The CHROSS checker. Journal Community Nursing 27(4) 25

Guest JF, Ayoub N, McIlwraith T et al. (2015) Health economic burden that wounds impose on the National Health Service in the UK. BMJ Open 2015;5:e009283 doi:10.1136/bmjopen-2015-009283 Harding K, Dowsett C, Fias L et al (2015)

Simplifying venous leg ulcer management. Consensus recommendations. Wounds International. Available online at: <http://www.woundsinternational.com/consensus-documents/view/simplifying-venous-legulcer-management> (accessed 18.07.2016)

International Consensus. Optimising wellbeing in people living with a wound. An expert working group review. London: Wounds International, 2012. [http://www.woundsinternational.com/pdf/content\\_10309.pdf](http://www.woundsinternational.com/pdf/content_10309.pdf)

Alderwick H et al (2015) Better value in the NHS. The Role of changed in clinical practice. Kings Fund. [https://www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/better-value-nhs-Kings-Fund-July%202015.pdf](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/better-value-nhs-Kings-Fund-July%202015.pdf)

Scottish Intercollegiate Guideline Network (2010) SIGN 120: Management of Chronic Venous Leg Ulcers. <http://www.sign.ac.uk/guidelines/fulltext/120/index.html>

Wounds UK (2016) Best Practice Statement: Holistic management of venous leg ulceration: London: Wounds UK. [www.wounds-uk.com](http://www.wounds-uk.com)

Wounds UK (2015) Best Practice Statement: Compression Hosiery: London: Wounds UK. [http://www.wounds-uk.com/pdf/content\\_12022.pdf](http://www.wounds-uk.com/pdf/content_12022.pdf). Contains Leg Ulcer Treatment Algorithm (Atkins and Tickle) Page 6.

Atkin,L,Tickle J. (2018) Best Practice Statement Leg Ulceration pathway: Revision required to reflect new evidence.( Wounds UK. Vol14.no 4.2018)

Gohel MS,Heatkey F,Liu X et al (2018). A randomised trialof early endovenous ablation in venous ulceration. (N ENGI J Med 378(22):2105-14)

Urgostart for treating diabetic foot ulcers and leg ulcers. Medical technologies guidance [MTG42] Jan 2019.NICE