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1st Quarter 2015
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**Vascular Nurse Specialists and Advanced Practitioners, please look out for a letter through the post. The SVN committee needs to know your opinion regarding our future roles**
Bursary Awards: Do you need some funds?

Kate Rowlands, Vascular Nurse Specialist, Cardiff and Vale UHB.

Did you know that if you are a member of the SVN, you can apply for a bursary? Yes…it’s true! Successful applicants can be awarded up to £500!

We all know that it is getting increasingly difficult, if not impossible to get funds from our work places to do courses, buy books or to travel to study days. There might an educational or research study you would like to do, which you know would improve vascular nursing care, but have been put off by the lack of finances. Well, this is where the SVN can be of help.

The SVN can award up to four awards a year, and to date there have been many successful applications. The bursaries have been used for a variety of ways; to help fund courses, from wound care and vascular disease modules to a PhD, or purchase study aids. Several nurses have used the money to attend the SVN conference, or to support the travel and accommodation costs.

Applying is much easier than you might think. The application form is available on the SVN website (www.svn.org.uk). It is not a complicated form; all we ask for are your details, and a paragraph of no more than 200 words which outlines the aims and objectives of the bursary request. There is more information on the SVN website which explains the application criteria in more detail.

All the requests are reviewed by the SVN committee which meets four times a year, following which you would be informed. Even if you have been awarded a bursary in the past, you can apply again!

Maybe you are already thinking of coming to the SVN conference this year in Bournemouth? Now you can apply for a bursary to help with the costs!

All we ask is that you tell us all about how you have used the bursary afterwards, maybe as a short article for the newsletter, or if you prefer, you can give a presentation at the conference.

So……think about how you could improve the care of patients with vascular disease by applying for this bursary….what have you been hoping to buy, or study?

If you have thought of applying but are still a bit unsure, or have some questions feel free to contact me via email at kate.rowlands@wales.nhs.uk.

Go on…apply!
President’s Welcome

Welcome to the spring edition of the Society of Vascular Nurses newsletter and my first as your president, I can only hope to continue to develop the role of nurses in caring for vascular patients as much as my predecessors. The conference in Glasgow was a roaring success, the feedback to the committee has been very positive, with great ideas which will help to shape next year’s conference. We would like to thank all members who attended on the day and helped to make it such a success.

This newsletter comes at a time when hospitals are under a great deal of pressure, with Accident and Emergency departments being busier than they have ever been. As you all know this has a knock on effect on the wards and departments with an increase in the pressure to discharge patients as soon as medically possible. At these pressured times it is vital that we focus on the patient and strive to provide high quality care. As we are aware vascular patients can have multiple healthcare needs, which often requires complex discharge planning. In my opinion the role of Vascular Nurses has never been more important in ensuring that these health needs of our patients are met.

One of the questions that we keep asking ourselves on the committee is what is a Vascular Nurse? Why is it different to other specialties? To try to help answer these questions the committee has developed clinical competencies, for both junior nurses and those working in an advanced nursing role caring for patients with vascular disease. These competencies are aimed at trying to give nurses the required skills to care for patients with vascular disease and aims to increase the standard of care provided to all vascular patients. Within Guys and St Thomas NHS Foundation Trust, where I work, all newly qualified staff are supplied with the Staff Nurse competencies on their induction, to provide them with a framework to develop their skills and knowledge they require to care for vascular patients. However, it’s important for members of the Society of Vascular Nurses to be aware that these are your competencies and as a committee we value your thoughts and opinions on these. Within this newsletter you will find a link to a ‘survey monkey’ where you will be able to feedback directly to the committee, and we would love to hear your thoughts. I hope you enjoy the newsletter.

Michael Van Orsouw
President of Society of Vascular Nurses

N.B. On a committee note, due to extenuating circumstances Claire Thomson will be acting as the SVN secretary in the interim.
NCEPOD Lower Limb Amputation: Working Together Launch November 2014

Debbie Ruff, Vascular Nurse Specialist, Pennine Acute NHS Trust.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) latest report, which was launched back in November 2014. Identified that “fewer than half of patients that needed leg amputation received quality care due to poorly co-ordinated inputs and a lack of multidisciplinary team working”.

Recent figures suggest that more than 5,000 people undergo a major amputation each year in England, Wales and Northern Ireland. Major amputation is a life changing experience that requires both patients and their carers to be supported by a wide range of health care professionals.

The Vascular Society of Great Britain & Ireland (VSGBI), previously published guidelines that aimed to improve patient quality care and reduce mortality to less than 5% by 2015. Given the mortality rate within this report was 12.4% we have a significant way to go to improve the outcomes for patients undergoing amputation.

The key findings from the report were as follows:

• Early review by a consultant vascular surgeon might have altered the outcome in 18/198 patients, particularly for patients admitted under other specialties.
• Nearly a quarter of (138/598 -23%) patients who should have had elective amputation underwent emergency surgery.
• Two-thirds of all delays would have been avoided if surgery had been performed on a planned operating list.
• 87% (452/516) of amputees did not have a named individual responsible for co-coordinating their discharge planning and rehabilitation.
• Only 12.8% (41/310) of patients with diabetes were admitted under the care of the diabetes service.
• Only 58.4% (160/274) of patients with diabetes were reviewed pre-operatively by a diabetes nurse specialist.
• The Advisors considered that glycaemic control was poor or unacceptable in at least one in seven patients at some point within the surgical pathway.
The key recommendations from the report were as follows:-

- A best practice clinical care pathway should be developed that supports the aims of the Vascular Society’s Quality Improvement Framework (QIF) for Major Amputation Surgery, and covers all aspects of the management of patients that require amputation.
- All patients with diabetes who need a lower limb amputation should be reviewed pre-operatively by the specialist diabetes team, to optimise control of diabetes and manage any co-morbidities.
- When patients are admitted to hospital under the care of a non-vascular specialist with limb-threatening ischaemia (poor blood supply), including acute diabetic foot problems, a vascular surgeon should review the patient within the first 24 hours.
- Amputations should be done on a planned operating list during normal working hours, in line with the QIF recommendation.
- Amputation should be carried out within 48 hours of the decision to operate. Any case waiting longer than this should be subject to local case review to identify reasons for delay and improve the organisation of care.
- Discharge planning that includes rehabilitation should commence as soon as the need for amputation is identified. All patients should have access to a suitably qualified amputation/discharge co-ordinator.

As a speciality we now need to communicate these findings within our multidisciplinary teams and health care managers to develop protocols and clinical pathways to ensure optimum care is delivered in order to improve the quality of care and outcomes for patients undergoing major limb amputation.
Poor diabetes care in England ‘costing lives’

Phillip Holdich is a Senior Lecturer in Nursing and Health Studies. University of Huddersfield.

State of the nation for England

The release of Diabetes UK’s annual report (Diabetes UK, 2015) State of the nation for England: Challenges for 2015 and Beyond makes for depressing reading. Between 2007 and 2012 avoidable complications such as amputations, diabetic retinopathy, renal failure and heart disease have increased. This is particularly marked in working age adults and patients with type 1 diabetes, many of whom may be young people.

Too many patients are not receiving essential checks to monitor their diabetes including blood pressure, cholesterol, HbA1c (longer term blood glucose), foot checks and tests for kidney function. This is not necessarily the same for all patients as there is clearly variation between clinical commissioning groups, the commissioning and provider services.

Many more patients with type 2 diabetes are receiving care at their local general practice, typically from a practice nurse whilst most people with type 1 diabetes are often managed in specialist diabetes centres at the local hospital. Without good support from these services, inevitably the outcomes for people with diabetes will worsen.

What’s going wrong?

Yet 20 years as a specialist nurse, diabetes educator and latterly researcher, has taught me one thing, everyone wants the best outcomes for patients but delivering services to meet their needs is challenging. So what’s going wrong?

Diabetes is a progressive disease, requiring regulation of diet and lifestyle, blood testing and attending clinical screening which can be difficult for patients who have to live with it, particularly for young people with type 1 diabetes. It requires regular monitoring and supportive care through good partnerships and sharing of responsibility between the patient and the clinician. We see patients for perhaps two hours at most in the year, the remaining 8763 hours is up to them!
Shift of care
There has been a shift of care, particularly for patients with type 2 diabetes, from hospital to general practice. Yet ongoing training for General Practitioner’s and Practice Nurses and support from specialist services is not always available. Over the last ten years, appointments outside of office hours have diminished as opening hours in general practice have decreased. So it may not be such as surprise that, for working adults and young people, access to services may be difficult.

Hospitals have had to make savings in real terms since 2008 which has impacted on diabetes care teams including the loss of some specialist posts for example in nursing. Furthermore, there has been a major upheaval in the landscape of the National Health Service, with the result that there has been no dedicated support in clinical commissioning groups (CCG’s) and developing diabetes services has been put on hold in many localities due to other priorities.

Whilst many areas continue to offer patient education for type 2 diabetes, such as DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed), the uptake by patients may vary and reports from the DESMOND project suggest that improvements in metabolic outcomes are not sustained in the longer term.

More radical thinking and policy is needed
Although moving public health into local government is a positive step, measures to reduce obesity and the risk of developing conditions such as diabetes need more radical thinking and policy, such as reducing the number of takeaways on our streets, stricter controls on calorie dense foods and increasing the unit cost of alcohol. The food and drink industry are powerful forces and their corporate interests are represented in government – unsurprising the will to challenge and regulate them is weak.

This is just a snapshot but the aim is to illustrate that this is a more complex problem. Diabetes UK is right to propose actions to address this, but, with another election looming and the likelihood of further changes to the structure of healthcare, it would be no great surprise to find the same rather depressing outlook in years to come. Exploring and addressing the underlying issues is paramount before prescribing the treatment.

MANAGEMENT OF VASCULAR PATIENTS: Level 5 or 6

Module Summary

This module is for practitioners working in a variety of settings to improve their knowledge and skills in caring for and promoting the health interests of patients with vascular disease

Learning Outcomes

- Demonstrate competency in assessment of vascular patients in both primary and acute care settings
- Demonstrate an understanding of physical processes and patho-physiological changes related to vascular health and disease
- Explore the role of the multi-professional team in the care of vascular patients
- Examine the role of pharmacological therapy in the care of patients with vascular disease
- Discuss the care of patients undergoing limb amputation including their physiological, psycho/social and rehabilitation needs
- Physiology of the circulatory system and related pathophysiology (workbook and follow up lecture)
- Incidence and prevalence of vascular disease
- Community screening for aortic aneurysm
- Aneurysmal and carotid disease
- Venous conditions and intervention
- Assessment, investigations and management of patients with intermittent claudication
- Radiological and surgical intervention for patients with peripheral arterial occlusive disease (PAOD)
- Pharmacology and adverse drug reactions
- High dependency care for vascular patients
- Role of multi-professional team
- Patients experience of vascular disease
- Ethical issues
- Psychosocial implications of vascular disease and rehabilitation
- Management of patients undergoing limb amputation
- Patients’ experience of limb amputation and rehabilitation
- Wound care in vascular patients
- Foot care for vascular patients

Course Dates 2014
Tuesdays- 8th April, 15th April, 22nd April, 29th April and 6th May

For Application Forms
Go to the Faculty website at www.healthcare.co.uk
Step 1 Choose Courses-CPPD-Faculty of Health, Social Care and Education
Step 2 Choose apply for a course
Step 3 Look under undergraduate short courses/modules etc. then choose option 2 all other undergraduate short courses/module etc.
Download the application form and complete
NB completed forms need to be with the Faculty by the 7th March at the latest
Save the date

**Thursday 28 - Friday 29 May**

**Venous Forum Spring meeting 2015**

**Venue:** Royal Society of Medicine, London

In a change to previously advertised, the Venous Forum Spring meeting 2015 will now be held on **Thursday 28 - Friday 29 May 2015**.

You are once again invited to **register your interest**, and save the date, for the next Venous Forum Annual Spring meeting 2015, which will be open for registration soon. The conference will host an array of world-renowned expert speakers, who will present various topics including thrombolysis for DVT and management of the recalcitrant ulcer.

The annual dinner, which takes place on the evening of Wednesday 22 April, includes a drinks reception and a three-course meal and is a fantastic opportunity to meet and network with other attendees and speakers.

**PROGRAMME HIGHLIGHTS**

- Foam sclerotherapy for ulcers debate
- Difficult venous cases - interactive session
- New VTE drugs and their complications
- Venous imaging
- Free paper sessions
- Interactive voting on key topics

Meeting coordinator:
Beilul Kahsai
Tel: 0207 290 3859
Email: venous@rsm.ac.uk
Web address: [www.rsm.ac.uk/venous](http://www.rsm.ac.uk/venous)

**This meeting is in association with the SVN**
Competency Feedback

Claire Thomson,

Dear SVN members, please take a minute to complete the survey monkey questionnaire that has recently been emailed to you via the SVN. We are passionate about the competency framework for vascular nurses in the United Kingdom and are aiming them at you within your specific workplaces. The competencies have recently been uploaded onto the SVN website www.svn.org.uk, and you will find the competencies within the ‘education’ section. This is the first draft version of competencies for ‘Advanced Vascular Nurses’ and we would dearly like your feedback both positive and negative, in order for us to amend the draft as needed, with the aim of creating a tool that you will be able to utilise for your clinical development, appraisal process and job perspectives.

The survey is produced on ‘survey monkey’ and should be in your email boxes; please check your junk folder if you cannot see it. Alternatively please email me at Claire.thomson@rbch.nhs.uk and I will email you a survey. To reiterate any feedback will be entirely useful as we wish to design the competencies with you in mind.

To view staff nurse competencies and Advanced vascular nurse competencies please go to www.svn.org.uk and click on ‘education’ >competencies

Many thanks for your time.
Improving Anticoagulation Therapy Services

Improving Patient Safety & Quality


20% discount to Society of Vascular Nurses
quote: ref hcuk20svn

Topics Include:

- Quality and safety indicators in Anticoagulation Therapy
- Monitoring adherence against the updated NICE guidance on Atrial Fibrillation
- Improving patients safety: Anticoagulation errors/near misses
- Developing a clinic service including risk management strategies for every patient
- Improving patient safety and experience through new oral anticoagulants
- Reducing Medication Errors and ensuring patients receive oral anticoagulation therapy within safe levels
- Educating frontline staff in the management of patients on the new oral anticoagulants
- Warfarin and NOAC monitoring

For further information and to book visit
http://www.healthcareconferencesuk.co.uk/anticoagulation
or email hanisha@hc-uk.org.uk
SVN Membership Form (also available online svn.org.uk)

FULL NAME:_____________________________________________________________________________

ADDRESS:______________________________________________________________________________

_____________________________________________________________________________________

___________________________________________________________POSTCODE:__________________

Email:_____________________________________________________Tel no:________________________

JobTitle:_____________________________________________________Grade:______Hospital_______

Area of work: (e.g. Community/Ward/Lab)__________________________________________________

MEMBERSHIP TYPE Full (circle as appropriate): NEW MEMBER / RENEWAL (all registered nurses)

ASSOCIATE (all other Healthcare professionals with an interest in vascular care)

WARD MEMBERSHIP
Does this include a Nurse Specialist? Name of Nurse Specialist: ___________

ANNUAL MEMBERSHIP FEE: £20
OVERSEAS MEMBERSHIP £25
WARD MEMBERSHIP £100

Cheques should be made payable to the ‘Society of Vascular Nurses’

In accordance with the Data Protection Act you are advised that enrolment information provided by members will be computerised and used for administration purposes. It may be shared with third parties in order to send you RELEVANT information (for example, information about vascular products, study days, courses, meetings etc).

I do not want my name and address circulated on mailing lists ☐ (please tick for NO)

Please return form and fee to:
Sue Ward VNS Vascular Assessment Unit, The Royal Sussex County Hospital, Eastern Road, Brighton BN2 5BE
Email susan.ward@bsuh.nhs.uk Tel 01273 696955 bleep 8213
A Surgeons Perspective of the Transition of Healthcare Delivery to Completely Nurse Led Services

Mr Ben Banerjee QVRM DL, Consultant Vascular Surgeon, Sunderland Royal Hospital.

Over the past 10 years we have seen an increase of clinical roles for our nursing colleagues, partly generated out of their desire to develop beyond the traditionally defined job but also as a result of the sequestration of junior doctors into EWTD (European Working Time Directive) and educationally focused commitments. There are some quarters that have and will continue to push back against such moves, however, it is no longer possible, in current climates, for everything to be consultant led. The major advantage of our nursing colleagues is their superior ability to communicate and more consistent healthcare delivery highlighted by patient satisfaction evidence.

At City Hospitals Sunderland we have treated varicose veins using endovenous techniques for 7 years. Analysing the clinical care pathway demonstrated to us that the value of the consultant opinion was in the decision making process and oversight rather than necessarily in the actual treatment delivery. Nowadays ‘choose and book’ patients go directly to a nurse led duplex ultrasound clinic where they are assessed with a history, examination and a duplex scan. This assessment includes a treatment modality suggestion that is then approved by the consultant. Following this the patient attends a therapeutic appointment that is nurse led with a supervising consultant. At this appointment the nurse will treat the patient with laser therapy and/or adjuvant ultrasound guided foam sclerotherapy. Safety measures also include the prior training and qualification of the nurse together with the opportunity for the consultant to have a face to face appointment at any stage should either the patient, nurse or protocol indicate. This practice has developed slowly over the 7 years with initially a consultant led service, followed by a mentoring phase and now a supervisory phase. We have no evidence suggesting any alteration in adverse outcomes or patient satisfaction.

Our clinical practice for the treatment of varicose veins has demonstrated that nurses can and will continue to adopt greater roles in healthcare delivery allowing medical resources to be devoted elsewhere thus improving efficiency.
The benefits of larval therapy in the management of leg ulcers

Nicky Stone, Associate Clinical Nurse Specialist Wound Management, Southend University Hospital NHS Foundation Trust.

Larval therapy has been used for a number of years and is widely utilised throughout the United Kingdom (UK) in the management of a variety of wounds, including leg ulceration. Over the last 14 years 20 million maggots have treated 30,000 patients in the UK and further afield, (Thomas (2006), cited by Benbow (2008).

As Thomas, (2006) notes, larval therapy claims to provide considerable advantages for the treatment of patients with leg ulceration, including speeding the healing process, controlling infection and effective debridement. However, Benbow, (2007) states that ‘larval therapy, also known as bio surgery or maggot therapy, is likely to provoke interest, disgust or both in many clinicians’.

I will discuss the benefits and issues relating to the use of larvae therapy in the treatment of patients with leg ulceration. These include debridement, infection (or bacterial) management and cost effectiveness. The issue of ethics and contraindications will also be discussed.

Leg ulceration affects between 1% to 2% of the adult population across the UK, United States and Europe, (Morison & Moffat, 2004). A survey by Moffat (2004), cited by Dealey (2005), found that 55% of patients had leg ulcers for longer than a year and 35% of patients for more than 18 months. Due to the prevalence and longevity of leg ulceration their effective management can be considered of real concern to the health care professional.

‘Leg ulcers are caused by a breakdown of epidermal and dermal tissue below the knee on the leg or foot that fails to heal’, (Moffat & Harper, 1997). The failure to heal can be due to a multitude of reasons, pressure, infection, tissue necrosis, age, chronic disease and venous insufficiency, (Johnstone et al., 2005) cite Hess, (2005). Hareendran et al., (2005), cited by Hoyle-Vaughan, (2006) notes that leg ulceration causes discomfort and can reduce a person’s inability to take part in normal daily activities. Significantly, as we shall see, it also imposes both a psychological and financial burden.

Larvae therapy in leg ulceration management is well documented, (Benbow, 2005; Thomas, 2006; Trudgian, 2002). Documented benefits include assistance with infection, cost reduction and debridement, (Morison et al., 2007). Benbow, (2007) agrees particularly with this last point, stating that ‘the larvae, or micro surgeons, are loved or hated by clinicians and patients, but all have to agree that they do a superb job of debriding wounds’.

Debridement

Leg ulcers are chronic wounds that do not progress through the usual four stages of wound healing. They are often characterised by excessive slough, necrosis and exudates. In examining the abruption of the phases of wound healing in leg ulcers Moffat et al., (2007) describe healing as a tightly controlled and ordered cellular process, however, notes that this distorts in the chronic wound and wound tends to become ‘stuck’ in the inflammation or proliferate stage. Chan et al., (2007) also observe that the presence of the slough, necrosis and infection often arrest the wound in the inflammatory phase.
Fletcher, (2008) argues that non-viable tissue such as slough must be removed, to allow the wound to heal and later noted that debridement has two key purposes:

- The removal of the physical barrier to healing
- The reduction in the microbes, toxins and other substances, which cause further damage within the wound.

Rajendran et al., (2007) discuss debridement in the patient with a venous ulcer and argue that if slough or necrotic tissue is present then it must be debrided in order to prevent infection and promote wound healing.

Debridement of chronic wounds such as leg ulcers can be achieved in various ways; Dowsett, (2002) classifies the methods of debridement as:

- Sharp
- Surgical
- Enzymatic
- Autolytic
- Mechanical
- Larval or maggots

Larval therapy, can be simply described as the introduction of live, sterile or disinfected maggots to a wound, (Twedell, 2009). Thomas and Jones, (1999) cited by Trudgian, (2002) state that larval therapy is suitable for various wounds including leg ulcers, pressure ulcers and diabetic foot ulcers where there is persistent slough and necrosis that cannot be removed with enzymes or hydrogels.

It has been clearly established that larval therapy is valuable for removing slough from many types of wounds. (Evans, 2002 cites Thomas et al., 2001; Knowles, 2001; Mumcuoglu, 2000; Murray, 1999). Jones and Thomas, (2000) state that “Larvae therapy is so effective that large amounts of dead tissue can be removed in a very short time”. Larvae also have the benefit of being able to control the production of offensive odour produced by proteolytic bacteria, (Thomas and McCubbin, 2002).

In practice larvae are placed onto the soft tissue to selectively debride the necrosis to promote wound healing. The maggot secretions contain proteolytic enzymes that breakdown necrotis into a semi liquid state which they then digest. This cleanses the wound of the devitalised tissue, (Thomas et al.,(2002). The larval action also induces the production of fibroblasts, to accelerate the healing process, (Drisdell, 2003, cited by Richardson, 2004). Jones and Thomas, (2000) note that once the enzymes come into contact with human tissue they are neutralised and will not remove viable tissue along with devitalised thereby sparing good tissue.

It is necessary to discuss the comparison between the use of larvae and hydrogels in the successful debridement of leg ulcers. Wayman et al’s., (2000) trial concludes that larval therapy was significantly more effective at debridement and could be provided at a lower cost. Research by Dunville et al., (2009) published in the British Medical Journal showed that larvae did not improve the rate of healing of sloughy or necrotic ulcers but did significantly reduce debridement time. Chan et al., (2007) examined the study by Sherman, (2003) in which twelve patients with leg ulcers where treated. Six patients had conventional therapy and six had larvae. The study showed that the group with maggots achieved complete debridement in three days whereas two of the six others had achieved debridement after one month and the remaining four required multiple dressing changes. Thomas and McCubbin, (2002) assessments found that with larvae 21% of the wound is debrided daily and in the case of a chronic sloughy wound a complete debridement is achieved in one application, an application was usually 3 days.
Managing infection

As previously noted leg ulcers are chronic wounds. Whilst all chronic wounds contain bacteria, just as the kind found on skin flora, increasing levels of virulent bacteria can cause tissue breakdown and thereby slow the healing process, (Moffat, 2007). The presence of necrotic tissue also acts as a medium for bacteria, Timmons, (2003) observes that this can prolong the inflammatory response and prevents the wound from contracting.

Larvae have powerful secretions that contain a mixture of proteolytic enzymes which cause necrotic and sloughy tissue to turn into a semi-liquid state. The maggots can then more easily ingest the non-viable tissue. Whilst feeding on the tissue the maggots ingest and reduce bacteria and wound infection, (Thomas & Jones, 2001).

It should be recognised that maggots are not capable of removing or reducing all bacteria. Studies show that whilst larvae are effective at removing gram-positive bacteria the larvae are not so efficient when they are in contact with gram-negative bacteria, (Trudgian, 2002). Steenvoorde & Jukema, (2004) explain that gram negative is more likely to thrive on a raised pH and this form of bacteria is able to destroy the valuable secretions created by maggots. It is also important to consider maggot therapy for individuals in whom antibiotics or surgery are ineffective, associated with high risk, or unavailable, (Chaudrey, 2008).

Contraindications

There appear to be very few contraindications from the use of larval therapy. Larvae do secrete ammonia and if the patient absorbs the secretions then his or her own ammonia levels could increase. Due to this Twedell, (2009) recommends that blood level checking is carried out if the patient is showing signs of increased confusion.

The positioning of the larvae should also be a consideration. Benbow, (2007) state that larvae should not be placed on a wound that tends to bleed or near any large blood vessels. In a study of 30 patients receiving larvae it was found that there was an increase in wound exudates temporarily, a mild increase in pain but only two patients required analgesia and one patient had venous bleeding, (Morison et al., 2007 cites Wollina et al 2002). However, Thomas et al.,(2002) write that the most common problem with larvae is that of pain with patients experiencing a picking sensation. Pain can also be caused by an increase in pH due to the maggots’ secretions and metabolic activity and is mostly associated in the patient with an ischaemic wound.

Ethics

Due to the public’s uninformed perception of maggots as ‘dirty’ and vectors of disease, it cannot be assumed that all patients will be happy to accept larval therapy, (Thomas and McCubbin, 2002). Indeed, it would be reasonable to think that the reaction of the members of the public to putting live maggots onto a wound would generally be one of disgust. However, in experience actual reactions are often at odds with this perception, with patients demonstrating intrigue, curiosity and a wish to find out more. This reaction can, in part, be explained by the positive attitude displayed by nurses to the treatment and the thorough explanation of the benefits of larval therapy. Clearly willing consent is needed and in order for the patient to give this they must be fully informed. Twedell, (2009) confirms that along with ensuring that the patient has informed consent, they must be carefully assessed for their ability to cope emotionally and psychologically with the idea of maggots feeding on their wound.

Financial

The burden on the National Health Service (NHS) for the treatment of leg ulcers is estimated to be 1.3% of the total annual budget, (Leach, 2004). Larvae therapy is thought to can play a vital role in making financial savings by reducing the cost of treating leg ulcers. Chan et al., (2007) cite Thomas & Jones, (2001) study which found that the use of larvae reduces debridement times, thereby reducing length of hospital stay. The average financial cost was approximately £82 compared with £503 in the use of conventional therapy, creating a substantial and valuable saving. Thomas, (2006) states that ‘if maggots where to be used as the treatment of choice for all sloughy and infected wounds, then this would result in an annual saving to the NHS of around £160 million’. Clearly this would reap a significant financial benefit to the health service as well as a huge saving of resources. Indeed, Twedell, (2009) observes that nurses now have to learn this ‘unusual’ therapy due to rising costs and resistance to antibiotics.
Surgery

For varying reasons it is not suitable for all patient to have wounds explored and debrided in theatre. The frail elderly do not make the best theatre candidates but, as Timmins, (2003) points out, the retaining of deep, sloughy and possible infected wounds must be carefully calculated over the risks of surgery. If surgery is a consideration, larval therapy as a debridement tool can give clinicians information on the extent of the damage and allow the team to decide if surgery is really necessary, (Evans, 2002, cites Edmunds & Foster, 2000). This may save possible risk to the patient with the added benefit of being a less expensive option. Evans, (2002) also believes that maggots are useful for the patient who may be an anaesthetic risk but would still benefit from rapid cleansing of the wound.

A further benefit of larval therapy is when autolytic debridement has failed or is contraindicated and sharp debridement may expose tendons, joints or bones, or as a secondary method after sharp debridement and prior to skin grafting, (Benbow (2007), cites Vowden and Vowden (2002).

Implications for practice

According to White and Sibbald, (2003) numerous centres around the world are known to be actively engaged in isolating and characterising some of the secretions produced by Lucilia Sericata (the type of larvae selected for medical use). The intention is that these could then be synthesized and incorporated into a convenient topical pharmaceutical formulation to replace the live maggot as a therapeutic agent. Evans, (2003) notes too the ongoing work in centres across the globe in characterizing maggot secretions so that they can perhaps be synthesized into topical agents. Chan et al., (2007) also anticipates the future work of using the secretions and excretion of maggots in hydrogels.

Conclusion

This article has shown that the key benefit of larvae therapy is the ability to promote rapid cleansing of necrotic and sloughy wounds of all kinds including leg ulcers by effective debridement. Further claimed benefits are:

• that the proteolytic bacteria help to control the production of offensive odour
• the actions of the larvae can help prevent or control infection
• the treatment can provide resource and financial savings associated with rapidly increasing the debridement times of leg ulcers
• Minimal contraindications

It must be considered that debridement is only a part of the numerous phases necessary to heal a leg ulcer and that other factors need to be taken into account. As Moffat, (2007) argues, the key to effective management of leg ulcers is the treatment and diagnosis of the underlying medical condition or conditions that predisposes the patient to leg ulceration. Wound bed preparation is only a part of the healing process. Thorough assessment and treatment of the cause is essential, as correction of these conditions alone can be the key to successful leg ulcer management. It is clear from that there are clear and tangible benefits to the use of these ‘little maggots’ and that they will continue to have a role to play in the setting of leg ulcer management. Finally, larvae needs to continue to be accepted by patients with leg ulcers and welcomed by healthcare professionals who are willing to adopt this therapy as part of wound care in practice. Maggot debridement therapy may regain popularity due to rising health care costs and resistance to antibiotics. Nurses must learn about this unusual therapy and be prepared to assist patients who are willing to try it’, (Twedell, 2009).
References


SVN Conference 2014 – Feedback
Louise Allen, Vascular Nurse Specialist, London

In 2014, the annual conference was held in the Scottish Exhibition and Conference Centre (SECC) on Thursday 27th November. There were a total of 87 delegates attending, 13 of which were committee members, and 9 were invited speakers. This also included the 6 James Purdie abstract presenters. The number of delegates was reduced this year, compared to 2012 and 2013, when there were a total of 130 and 100 delegates respectively. It is difficult to predict why the numbers have reduced, but I am sure it is becoming increasingly difficult to get funding and time away from work.

As usual the conference began with the James Purdie prize presentations, and this year we had seven abstracts accepted for presentation. The prize is a cheque for £500 awarded by the Circulation Foundation, and is decided by members of the committee and the audience. The 2014 winner of the James Purdie prize was Bernie Hannon, Clinical Nurse Manager, for her abstract presentation ‘Lessons to be learnt from the establishment of an Ambulatory Care unit for the treatment of Varicose Veins’. Unfortunately there were no submissions for the poster prize this year, but I would encourage everyone to consider submitting a poster for this year’s conference. It is an excellent method to advertise and share your work with other vascular nurses, and there is also a prize for the best poster.

As usual we asked all the delegates to complete the evaluation form to help us plan and improve the following year’s conference, and to also audit those attending the conference to ensure we know who our audience is. This year we had 35 completed evaluation forms, which is a 53% response rate. Despite an increased number of delegates in 2012, we only had a response rate of 28%.
The speakers from each symposium were awarded a maximum of five points for their presentation, content and relevance, giving a maximum of fifteen points in total. Review of the evaluation forms showed that all the speakers scored well, reassuring us the conference programme, agenda and speakers are appropriate and appreciated by you all. The minimum score was 12.41 (83%), and the top score was 14.63 (98%), giving an average score for the conference of 13.8 (92%). All these figures were higher this year, than the previous year. The two symposiums’ that scored the highest were Symposium 1: Challenges to Quality of Care of the Vascular Patient and Symposium 3: Varicose Veins Update.

The scores for the venue and facilities, organisation of the day, pre-conference information received, exhibition, value for money, and overall impression, were also awarded a maximum of five points each. The overall impression of the conference scored 4.56 (91%) and the average score of all the categories was 4.51 (90%). The lowest score was 4.21 (84.2%) for the exhibition, and the highest score was 4.74 (94.4%) for organisation of the day. All these figures were an improvement when compared to last year.

The audit section of the evaluation form showed that as usual the majority of the delegates were senior vascular nurses, working in a vascular nurse specialist role. There were a few ward based nurses, however less allied health care professionals attended this year. Most of you heard about the conference through the newsletter, or another member, and despite the economic climate it is encouraging that 97% of you were both funded to attend and had study leave to attend. This increased by 7% compared to last year.

We had our third evening symposium the night before the conference this year, which 50% of those that completed the evaluation form attended. This is an opportunity to network with colleagues, in a sociable environment with drinks and nibbles, as well as meet industries related to vascular disease. The highlight of the symposium was the opportunity to hear our guest speaker Mr Nick Gowland-Hopkins, who gave an enlightening and frank presentation on his experiences working in Africa, entitled ‘A Vascular Surgeon in Africa’.

The SVN committee look forward to seeing you all in Bournemouth, in November this year.
The SVN will shortly be announcing the dates for the annual SVN Evening Symposium and SVN Conference.

Further details will be in the Spring Edition of Vascular Matters and via the SVN Website svn.org.uk