Withdrawn March 2020.

Venous leg ulcer:
Give patient “safety net instructions” and review need for antibiotics at three days with swab result.
Swab viable tissue which displays signs of infection, whilst rotating the swab. Alternatively, use the Levine technique in which the swab is pressed into the ulcer bed, as this displaces deeper placed organisms.

1. Use a swab with charcoal transport medium.
2. Cleanse the wound with tap water or saline to remove surface contaminants, slough and necrotic tissue.
3. Swab viable tissue which displays signs of infection, whilst rotating the swab. Alternatively, use the Levine technique in which the swab is pressed into the ulcer bed, as this displaces deeper placed organisms.
4. Send the swab to the microbiology laboratory as soon as possible to aid survival of fastidious organisms.

Microbiological samples should always be collected before antibiotics are started.

For all specimens, include all clinical details (patient details, site, nature of wound and current or recent treatment), to enable accurate processing and reporting of the specimen.

When should I use antiseptics or antibiotics in venous leg ulcers?
Topical antiseptics may be of benefit to individual patients, but are not routinely recommended in the treatment of venous leg ulcers. Some evidence supports the use of cadexomer iodine for critically colonised ulcers or early infection, but further research is required before other recommendations can be made.

Systemic antibiotics only if locally spreading cellulitis or other signs of clinical infection.
Give patient “safety net instructions” and review need for antibiotics at three days with swab results.

First line treatment if there is locally spreading cellulitis or other signs of clinical infection:
- empirical therapy with oral flucloxacillin, 500mg-1g (dependent on BMI), four times a day, to cover staphylococci and Groups A, C and G streptococci if penicillin-hypersensitive, clarithromycin, 500mg, twice daily; if penicillin-hypersensitive and on statins, doxycycline, 200mg stat and then 100mg daily if cellulitis is persistent, clindamycin is an alternative, stop clindamycin if diarrhoea develops all antibiotics to be prescribed for 7 days; if there is slow response, continue for a further 7 days discuss with local microbiologist for any antibiotic advice needed, or treatment choice for MRSA.

Consider need for referral to secondary care if infection is non-responsive or patient is systemically unwell.

INTERPRETING THE LABORATORY REPORT
The result will only provide information about the organisms present and their antibiotic susceptibilities.

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BACKGROUND

 Venous leg ulcer: “the loss of skin below the knee on the leg or foot, which takes more than 6 weeks to heal”.

CKS □ Venous leg ulcer: “the loss of skin below the knee on the leg or foot, which takes more than 6 weeks to heal”.

NICE □ Give patient “safety net instructions” and review need for antibiotics at three days with swab result.

SIGN □ Swab viable tissue which displays signs of infection, whilst rotating the swab.

WHERE SHOULD I TAKE A MICROBIOLOGICAL SAMPLE FROM A VENOUS LEG ULCER?

If there are any of the following criteria that indicate the presence of infection:
- increased odour or increased exudate from the ulcer
- enlarging ulcer with abnormal bleeding or bridging granulation tissue
- increased disproportionate pain
- cellulitis (particularly if spreading), lymphangitis or lymphadenopathy
- pyrexia, systemic inflammatory response syndrome or sepsis

Microbiological samples should always be collected before antibiotics are started.

Non-healing or atypical venous leg ulcer: refer for consideration of biopsy.

Intervene if the patient is unwell:
- increased disproportionate pain
- cellulitis (particularly if spreading), lymphangitis or lymphadenopathy
- pyrexia, systemic inflammatory response syndrome or sepsis

When should I use antiseptics or antibiotics in venous leg ulcers?
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Consider need for referral to secondary care if infection is non-responsive or patient is systemically unwell.

KEY: □ = good practice point

Next Full Review: March 2019
GRADING OF GUIDANCE RECOMMENDATIONS

The strength of each recommendation is qualified by a letter in parenthesis. This is an altered version of the grading recommendation system used by SIGN.

<table>
<thead>
<tr>
<th>STUDY DESIGN</th>
<th>RECOMMENDATION GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good recent systematic review and meta-analysis of studies</td>
<td>A+</td>
</tr>
<tr>
<td>One or more rigorous studies; randomised controlled trials</td>
<td>A-</td>
</tr>
<tr>
<td>One or more prospective studies</td>
<td>B+</td>
</tr>
<tr>
<td>One or more retrospective studies</td>
<td>B-</td>
</tr>
<tr>
<td>Non-analytic studies, eg case reports or case series</td>
<td>C</td>
</tr>
<tr>
<td>Formal combination of expert opinion</td>
<td>D</td>
</tr>
</tbody>
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This guidance was originally produced in 2006 by the South West GP Microbiology Laboratory Use Group, in collaboration with the Association of Medical Microbiologists, general practitioners, nurses and specialists in the field. This guidance was reviewed and updated in 2016, with input from Professor Cliodna McNulty; Dr Philippa Moore; Professor David Leaper and Jacqui Fletcher (Cardiff University); the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI); the British Society for Antimicrobial Chemotherapy (BSAC); the British Infection Association (BIA); the Royal College of General Practitioners (RCGP); the Royal College of Nursing (RCN); general practitioners; specialists in the field; and patient representatives. Full consensus of the recommendations made was given by all guidance developers and reviewers prior to the dissemination of this guidance. All comments received have been reviewed and incorporated into the guidance, where appropriate. For detailed information regarding the comments provided and action taken, please email sarah.alton@phe.gov.uk. Public Health England works closely with the authors of the Clinical Knowledge Summaries.

If you would like to receive a copy of this guidance with the most recent changes highlighted, please email sarah.alton@phe.gov.uk.

For detailed information regarding the search strategies implemented and full literature search results, please email sarah.alton@phe.gov.uk.