# Ulcers

## A) Inspection: we should note

| Inspection |
|---|
| 1) Size & Shape |
| 2) Number |
| 3) Location |
| 4) Margin & Edge |
| 5) Floor |
| 6) Surrounding skin |

1) Size and shape of the ulcer (using a tape measure)

2) Number (single or multiple)

3) Location of the ulcer:

- Varicose ulcer → medial aspect of lower third of the leg
- Rodent ulcer → nose
- Tuberculous ulcer → neck
- Trophic ulcer → weight-bearing area (e.g. heel of the feet)
- Bedsore ulcer→ sacrum
- Ischemic dorsum of foot and toe

4) Margin and Edge of ulcer

- *Margin* is the border or transitional zone of skin around an ulcer. Types:
  - Healing margin [white (outer) – blue (central) – red (Inner)]
  - Inflamed margin (red, irregular margin with inflamed surrounding skin)
  - Fibrosed margin (thickened white)
- *Edge* is the mode of union between the floor and the margin of ulcer. Types:
  - Sloping edge → healing ulcer
  - Punched edge → trophic ulcer
  - Undermined edge → tuberculous ulcer
  - Everted edge→ malignant ulcer
  - Raised edge → rodent ulcer

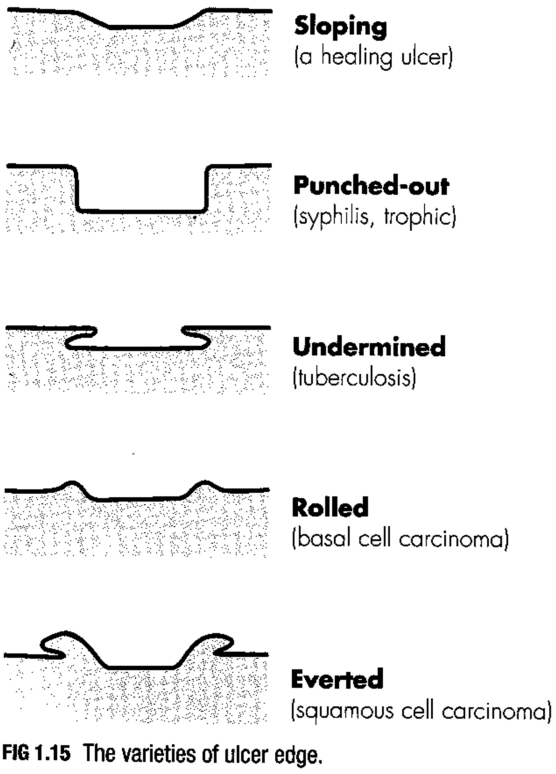

FIG 1.15 The varieties of ulcer edge.

5) Floor of ulcer: is the exposed surface of the ulcer, we look for

- Type of Granulation tissue
- Amount of Slough (necrotic soft tissue not yet separated from living tissue)
- Nature of Discharge

6) Surrounding skin: if ulcer is spreading and infected the surrounding skin is shiny, red, edematous due to cellulitis

- Dark pigmentation & eczema → varicose ulcer
- Scars and puckering of skin → tuberculous ulcer
- Hypopigmentation → non-healing ulcer
- Large scar→ Marjolin's ulcer

## B) Palpation: for

1) Surrounding skin: for temperature & tenderness

2) Ulcer: edge, floor, base

Edge

- Soft: healing ulcer
- Firm: non-healing ulcer
- Hard: malignant ulcer

Floor:

- Granulation tissue: bleeding on touch? Healthy granulation tissue may show pinpoint hemorrhagic spots, while malignant ulcer may bleed profusely
- Slough: attached loosely or firmly?

Base (tissue on which the ulcer rests):

- Consistency
- Underlying structures (muscle, fascia or bone?)

3) Test the fixity of the ulcer to the structures in its base

### Paplation

1) Surrounding skin
2) Ulcer: edge, floor, base
3) Test the fixity

## C) Focal examination

1. Regional Lymph node
2. State of arteries, venous circulation, nerves
3. Movement of neighboring joints

Lymph nodes

- Hard, discrete, non-tender → malignant ulcer
- Soft, tender → infective
- Non-tender, matted → tuberculous ulcer

State of arteries, veins, nerves

- If ulcer in lower limb: ask patient to stand and look for varicose veins, varicosities, also test for DVT by calf tenderness (Moses sign) and Homan's sign (pain on passive dorsiflexion of foot).
- For any ulcer palpate arteries to rule out vascular disease & arterial insufficiency
- Test sensation of skin surrounding ulcer by sharp pin
- In trophic ulcer we should
    - Map area of anesthesia
    - Search features of Leprosy
    - Neurologic exam

Examine joint around ulcer for active and passive movement

## D) Systemic examination

- CVS: for CHF which delays ulcer healing
- R.S: for TB & secondaries
- A.S: for splenomegaly