Case Report

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Masquerading Venous Ulcer as Unstable Scar: A Case Report

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Abstract

Venous ulcer is a common manifestations of untreated chronic venous insufficiency affecting only about 5% of those with the condition.[1] Many at times venous ulcers are easy to identify, and to start the appropriate treatment. However, in post skin graft patients where the depth of primary injury is unknown and the assessment of superficial veins is not always possible clinically, the diagnosis of venous ulcer may be delayed.

We present one such case in our institute where the venous ulcer was initially treated as an unstable scar with ulceration.

Keywords: Unstable scar, Venous ulcer, Doppler Ultrasound.

INTRODUCTION

Estimated prevalence of chronic venous insufficiency in developed world is between 20% -30%.[2] Only about 20% of them present with venous ulcers. Venous ulcers can have catastrophic consequences with sudden torrential bleeding if left untreated.[3] The various risk factors include advancing age, prolonged standing, female gender. In majority of them the diagnosis is quite evident with good healing if treated appropriately. We present a case of ulcer over the medial mallelous of left leg with multiple discharging sinuses over lower 2/3rd of leg in a patient with history of previous split skin grafting over the same region.

MATERIAL AND METHODS

Our patients is a 46 yr male with history of trauma to his left leg 8 years ago for which open reduction and internal fixation of the bone was done along with Split skin grafting of the raw area over the antero-medial aspect of leg. For 8 years patient had no complaints. Following which he noticed a small ulcer over the antero-medial aspect of left leg for which regular dressings were done at local hospital. As the wound didn't improve for 2 years patient came to Plastic Surgery Department at our centre which is a referral centre.

It was initially diagnosed as infected ulcer secondary to unstable scar over the graft site and was managed with antibiotics according to culture sensitivity (*Fig. 1 & 2*). Patient also complained of itching around the ulcer with scabbing and regular peeling off of the skin. Multiple discharging sinuses were noted Dermatology consultation was obtained and diagnosed as ichthyosis and was advised emollients. Patient was lost to follow up for 3 months after which he was admitted with closed fracture of right tibia and fibula following a road traffic accident.

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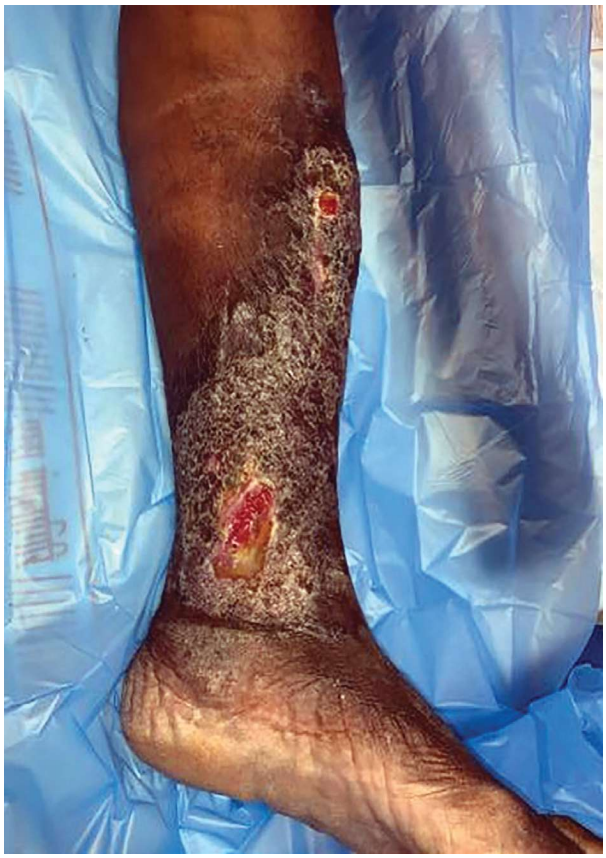

Fig. 1: Showing the infected ulcer with surrounding skin scabbing

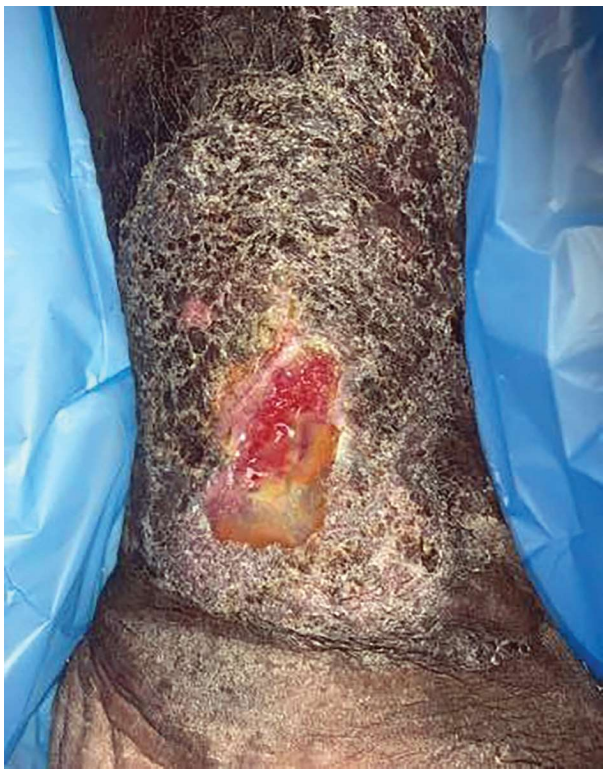

Fig. 2: Close up photo of the ulcer

At the same admission, venous doppler was done which showed varicosities of superficial veins. Patient was once again managed with regular dressing and rest. The wound improved well (*Fig. 3*) and healed completely.

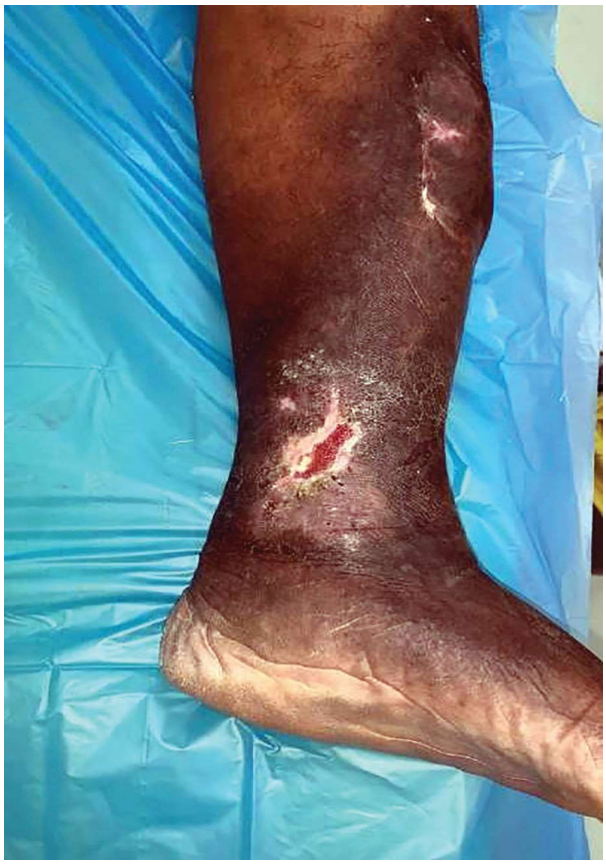

Fig. 3.3: Showing the healing ulcer with improvement in surrounding skin

RESULTS

Overall improvement of the wound was satisfactory and didn't require any surgical intervention. Patient was advised class 2 compression stockings. At 6 months follow up, patient had no further ulceration.

DISCUSSION

Recurrent microtrauma, dryness in a skin graft recipient site is the most common cause of ulceration at graft site. Unstable thin grafts do not posses sebaceous glands leading to dryness and itching which can further lead to ulcer formation.[4] In this patient the scabbing of surrounding skin with multiple discharging sinuses had lead to the diagnosis icthyosis with unstable graft and ulceration. This

has has masqueraded the actual diagnosis of venous ulcer. Another important factor was that the patient was lost to follow up and was only compliant with assessment and management due to rest advised for fracture of both bones of the leg on the opposite side.

The absence of tortuous veins and reticular veins due to the previous skin graft at the same region and examination revealing significant pedal edema with super added infection led to the delay in diagnosis of the ulcer.

This case highlights the importance of considering venous insufficiency as one of the differential diagnosis in patients presenting with ulcers over previous skin grafts and the necessity of further diagnostic investigation when initial treatment fails.

CONCLUSION

Skin grafting makes it difficult to identify the cause of ulcer in the leg as the first diagnosis would be that of an unstable scar.

However, the surgeon should have a low threshold for additional diagnostic investigations to identify and treat the underlying cause of the ulcer. Early and appropriate management, including compression therapy, is crucial for optimal outcomes in venous ulcers.

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