Ulcerated lesions

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Traumatic ulceration

When ulceration appears after trauma to the skin it is usually the result of an underlying trigger such as skin thinning (either age or steroid related), oedema, poor blood supply or excessive tension on the skin. Early intervention following skin trauma, with appropriate dressings and treatment of infection, can help prevent the development of an ulcer. In this case, infection caused a delay in healing and an ulcer developed on the skin overlying the tibula, an area of high risk.



Neuropathic ulcer

Neuropathic ulcers occur most commonly on the lower limbs in patients with a sensory nervous system deficiency. The most common cause is poorly controlled diabetes. It is estimated that 15% of patients with diabetes will suffer from foot ulcers at some time during their life. The ulcers develop as a result of repetitive trauma to an area of sensory loss and are often caused by ill-fitting footwear. Typically, the patient is unaware of this until the ulcer is noticed. Hence early diagnosis of peripheral neuropathy is vital. It is important to educate patients about checking their feet regularly to look for early signs of damage.



Venous ulceration

Venous leg ulcers usually develop secondary to venous insufficiency and account for 85% of all leg ulcers. They are more common in women and are typically found over the medial malleolus. Treatment approaches include addressing the underlying venous problems with surgery, if appropriate, or compression ideally with three-layer bandaging. Before initiating treatment coexisting arterial problems need to be ruled out by checking the ABPI using a handheld Doppler device. Management may also involve the use of analgesics, diuretics and antibiotics.



Nodular basal cell carcinoma

Rodent ulcer is the common term used to describe nodular basal cell carcinoma (BCC) as the lesions resemble rat bites with a raised edge and central ulceration. In the early stages it presents as a nodule often with surface telangiectasia. Treatment is usually by excision. Mohs surgery is generally the preferred option especially for recurrent disease. Not all BCCs are ulcerated, superficial BCCs are usually scale-covered plaques which are often misdiagnosed as psoriasis.



Aphthous ulcers

Aphthous ulcers are very common and can occur anywhere within the mouth. They can result from trauma to the buccal mucosa, often inflicted with a toothbrush, and usually resolve without treatment in 10-14 days. However, very painful ulcers can be treated with topical steroids in the form of pellets or lozenges. Differential diagnoses include herpetic ulcers which are usually smaller in size (aphthous ulcers are 2-4 mm in diameter) and occur in crops of multiple tiny ulcers. Herpetic ulcers are often preceded by a burning sensation in the affected area. Unlike herpetic ulcers, aphthous ulcers are not contagious.



Pyoderma gangrenosum

Pyoderma gangrenosum is an uncommon ulcerative disorder which was first described in the 1930s. The cause is still unknown. The condition is associated with systemic disease such as rheumatoid arthritis in at least 50% of cases. The ulcers typically occur following trauma to the affected area and have a bluish undermined serpiginous edge. Differential diagnoses include: squamous cell carcinoma; ecthyma; Behçet's disease; and venous insufficiency (if the ulcers occur on the lower legs). Rarely, severe cases may be fatal.

