Using an outreach service to meet the needs of users of intravenous drugs with leg ulceration

Intravenous drug use can result in leg ulceration, causing pain and distress. Healthcare services need to respond to this frequently unrecognised problem.

INTRODUCTION

It is estimated that 88% of intravenous drug users have signs of vascular damage to their legs and 55% of these have signs of severe venous disease (Pieper and Templin, 2001). In spite of this, Department of Health (2007) guidelines on drug misuse and dependence do not mention venous disease or leg ulceration.

Studies consistently show that the UK has one of the highest rates of recorded illegal drug use in the western world (DH, 2007). In particular, the UK has high rates of heroin and crack cocaine use. Although both of these can be smoked, most clients inject – this is considered a cheaper option because a smaller quantity of the drug is required to achieve the same effect.

Any vein can be used for injecting but once surface veins become damaged deeper ones, such as the femoral vein or jugular vein, are often used. The femoral vein is often used repeatedly for years (Fig 1), which results in scar tissue leading to stenosis (narrowing), which obstructs venous blood flow. Clients in their early twenties often have signs of hypertrophic skin changes and ankle flare, which are common signs of venous disease.

Street heroin needs to be mixed with an acid in order to make it into an injectable substance. Common acids used for this purpose include citric acid and vitamin C, which can be purchased in powder forms or are given out in needle exchanges. There is little research into the effects of using such acids on the lumens of veins. Street heroin is also often mixed with filler materials by dealers so the product will go further; this may be done in unhygienic environments.

Using crack cocaine can accelerate the rate at which venous damage occurs because the drug has a short term action, giving a short lived feeling of euphoria and wellbeing. As the effects of the drug wear off, users often become tense and paranoid and this leads to repeated use to try to recapture those initial feelings. Such behaviour can result in a crack binge, when a user may inject into the

FIG 1. INJECTING INTO THE FEMORAL VEIN CAN CAUSE VENOUS LEG ULCERS
Box 1. Case Study

Steven is a white working class man from a deprived area. He rarely attended school and left with no qualifications. He grew up in an area where many of his peers used either drugs or alcohol to excess. His father died when he was six and his mother had problems with alcohol for as long as he could remember. Steven is the third of six children and has two older brothers who have had problems with heroin. His first experience with this drug was when he was 16 and he has been injecting in his femoral vein since the age of 19; he is now 31.

By the time Steven was 27 he had developed leg ulcers. At this time he was homeless and lived in a violent, dangerous and uncomfortable world. He had no real friends and spent much of his time feeling ill as a result of the beginnings of withdrawal and pain from his leg ulcers. These were infected and smelled offensive. When Steven injected heroin his problems were forgotten and he described it as the only reliable thing in his life. He knew it was the cause of many of his problems but gave him a break from his own reality.

I began treating Steven two years ago and first met him at a clinic run from a pick-up point for vendors of The Big Issue. At first he was reluctant to accept care and was obviously ashamed of the condition of his legs. He dressed them with toilet paper from the public toilets in the town centre and it took time to remove this and reach his wound. Steven was in a rush during this first visit as he was beginning to withdraw and had to sell his femoral vein up to 20 times in one day. There is also a trend among new drug users to use the femoral vein instead of superficial veins because the injection sites are not visible and the vein is easy to access.

Further damage to veins can occur when clients develop deep vein thrombosis (DVT). The link between IV drug use and DVT is well established (Cooke and Fletcher, 2006; McColl et al, 2001) but is often overlooked as a risk factor for venous disease in this client group.

Accessing Wound Care Services

Accessing healthcare can be difficult for clients who use IV drugs. Many have extremely transient lives, moving from city to city as well as within a city. This makes registration with a GP difficult and keeping appointments is also an issue. In my experience, most clients are worried about their health but are more concerned with the prospect of withdrawal – as such, making money to fund drug use is generally their first priority. Failure to access leg ulcer care means wounds may deteriorate and ultimately require a lengthy hospital stay. Once patients are discharged they may again fail to attend clinic appointments and a cycle of crisis management develops.

Meeting the Need for Leg Ulcer Care

Providing healthcare for clients who use IV drugs is challenging. Our client group tend not to use statutory services and are frequent non-attenders for clinic appointments so it was decided that outreach drop-in clinics were the most likely way to engage this group.

Clinics were set up in venues across Sheffield, including the main needle exchange project run by Turning Point and a project run by the cathedral to give homeless people breakfast. All of our clinics are run on a drop in basis with appointments available for those clients who may have jobs or are recovering and may not wish to have contact with current drug users. When the service was established it was anticipated that most staff time would be taken up with treating minor illness. However, it soon became clear that wound care, and in particular leg ulcer care, is a huge and unrecognised problem for this client group. We liaised with the city’s community tissue viability service and were soon regularly dressing clients’ wounds.

Within three months of starting a clinic at the needle exchange service, we were regularly seeing more than 60 clients a month for leg ulcer care. We now provide 12 clinics a week across seven different venues and had more than 1,300 wound care consultations last year.

Providing effective wound care can have a profound effect on patients’ lives but also presents challenges. Many clients do not reattend when asked; this often leads to nursing staff worrying about clients who may have the same set of bandages on for three weeks. Clients often refuse to wait for ankle brachial pressure index measurements, which can mean applying compression on the basis of their history and symptoms. These problems have been overcome as the client group were very gradually come to know and trust the service. Clients now usually come back when asked and usually allow the time required to provide a comprehensive assessment.

Conclusion

Although leg ulceration is a common problem associated with IV drug use, it is often unrecognised. The outreach service aimed to meet the health needs of clients who use IV drugs and identified problems with wound care among this group. The service responded to this need by offering flexible wound care to clients. Developing a model that is based on outreach has meant many clients have had hospital admissions drastically reduced. This model of outreach nurse led health services is effective and provides nurses with new opportunities to develop advanced practice.

References


