



Invited Commentary

Commentary on “Changes in the Aetiological Spectrum of Leg Ulcers after a Broad Scale Intervention in a Defined Geographical Population in Sweden”

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Lower extremity ulceration can lead to significant morbidity and mortality in all societies. Forssgren et al. have nicely documented a decreased rate of arterial and venous ulcer with a program instituted in a small region in Sweden. They also demonstrate a decreased rate of amputation. Although this data is impressive and I would like to congratulate the authors for their excellent work, I have some concerns about the study.

My two biggest concerns relate to the timeframe evaluated during the study and the population utilized for the study. The study data was accumulated after a program was initiated to reduce the rate of ulceration. Data was collected until 2002. Therefore, the data is a decade old. But, there is clearly still value to the improvement in the rate of ulcerations seen in this region of Sweden after the implementation of their program. In addition, the authors have responded to this concern in an appropriate fashion and believe that the ulceration and amputation rates may be even further decreased in 2012 as the program has continued to grow and is widely accepted. The morbidity of interventions may be decreased since the study was completed as well. A similar number of interventions (228 in 2002 as compared to 234 in 2011) were performed, but the number of interventions being completed in an endovascular fashion has increased significantly (21% in 2002 as compared to 52% in 2011).

As for the study population, this is a relatively homogenous group and likely the program may be difficult to widely apply

throughout the diverse populations in other parts of the world. In addition, the study population has a mix of arterial and venous patients. It appears that the program has improved care for both arterial and venous patients individually, but the data is mixed because of the types of patient included. And, the authors clearly state the patients with multifactorial ulcers seemed to increase during the study period despite the decrease seen in the arterial and venous patient groups. I believe that many patients with venous stasis ulceration are also impacted by peripheral arterial disease. I would expect that a program instituted with the intention of decreasing any ulceration should improve the rate of ulcerations even in patients with a multifactorial etiology. I believe that my personal experience and the literature support this statement. Efforts to improve an arterial or venous issue should likely improve patients with multifactorial ulcerations as well.

Most importantly, this well-designed and executed study gives both physicians and patients optimistic findings. Patients with arterial and venous ulcerations can be exceptionally challenging to treat. These wounds and the necessary wound care lead to significant socioeconomic losses for previously functional individuals, especially the younger patients with venous stasis wounds. A program that was accepted and instituted appropriately in Sweden clearly led to a reduction in ulcerations and amputations. We should strive to apply these principles everywhere to make the care for patients with ulcerations safer and more efficient.

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