General practitioners are at the heart of managing ulcers in the community

Nagalaxmi Iyengar

> *You must lance an ulcer to heal it. You must tear down parts of an old building to restore it, and so it is with a sensual life that has no spirit in.*
>
> – Rumi[1]

While it is universally accepted that an ulcer is defined by the full-thickness erosion of an epithelial lining,[2] the aetiology and management of different types of ulcers remain distinct, elusive and, at times, misunderstood. Australian Nobel laureate Barry Marshall noted that as peptic ulcers became more common in the 20th century when theories of Freud and other psychoanalysts became popular, the tradition emerged that gastric ulcers were interwoven with the stress or turmoil in one's life,[3] since shown to be incorrect.[4] Although the disability from lower limb wounds,[5] the shame and fear associated with genital ulceration[6] and the pain of corneal ulcers are not synonymous with causation, the emotional and psychological impact may be profound.

My hospital-based medical training focused on the characterisation and pathophysiology of ulcers that are secondary to venous or arterial disease and, in particular, within the context of diabetes. Despite what seemed to be adequate preparation at the time from my training and experience within the tertiary referral hospitalist context, once commencing general practice training I realised there was much to learn. In the community context, my general practitioner (GP) supervisors, mentors and colleagues revealed their extensive breadth of knowledge and experience to assess and coordinate the management of ulcers across all stages of wound healing. GPs are ideally situated to consider the broad range of disease-driven variations in presentation and progression, especially in less common locations such as the genital region[7] or cornea.[8]

In this month's issue of *Australian Journal of General Practice* (*AJGP*), Sinha and colleagues explore the art and science of selecting wound dressings for acute wounds.[9] McMorrow and colleagues discuss detection of peripheral neuropathy to prevent complications of diabetic foot ulcers.[10]

Mack et al provide a rationale to enable GPs to diagnose different types of corneal ulcers.[11] Weerasinghe and Ooi present a case study of a penile ulcer and explore treatment options.[12]

In addition to these ulcers, which are on the external surface of the body and hence visible to the patient, this edition of *AJGP* also considers important yet not directly visible ulceration in the upper gastrointestinal tract.[13,14]

The diagnosis and management of ulcers can be a complex and satisfying conundrum. The diversity of aetiology means exercising the hallmarks of good general practice, which include a sound clinical acumen, patience in history-taking and management over time, coping with uncertainty and, importantly, good networks with allied health professionals. A better understanding of the management of ulceration will facilitate the comprehensive care provided by GPs, who also manage the physical and psychological sequelae of ulceration.

Author

Nagalaxmi Iyengar MBBS, PhD, BSc (Hons I), Editorial Fellow, *Australian Journal of General Practice*; General Practice Registrar, Melbourne, Vic

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