That's just the way it is

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Historic readers of *The Diabetic Foot Journal*, when it used to be in print, will know that my major interest outside of healthcare is music. I would always include a musical reference, title or lyric, in every editorial I wrote. This title refers to Bruce Hornsby and the Range's 1986 (and only) Top 40 single of the same name. As the chorus states, "Some things will never change", which is true of my editorial titles and of diabetes foot care. On 1 February 2025, I will mark my 30th anniversary of becoming a consultant diabetologist. During this time, the management of diabetes has changed beyond recognition.

Prior to 1995, the treatment options for type 2 diabetes were essentially sulphonyureas, metformin and insulin. We now have glitazones, DPPIV inhibitors, GLP1s and SGLT2s. Even within GLP1s, things progressed from twice daily to once daily then once weekly and even an oral option. This year, tirzapetide — the first dual GLP/GIP modifier — was approved for NHS use for diabetes. Sometimes it feels that a new diabetes medication for type 2 emerges every month. Similarly, for insulin-treated patients the development of analog insulins has moved at a rapid pace. From the introduction of human sequence insulins to analogs, more recently ultra long-acting insulin and very rapid insulins, has meant learning about a new insulin every year. Soon we will have once weekly basal insulins to get to grips with.

Monitoring has undergone a revolution from reading the colour of a glucose test strip against the tin to continuous glucose monitors and a whole new language of time in range and glucose variability. Insulin delivery systems moved from syringes to pens to pens with Bluetooth, dumb tethered pumps to pumps with hybrid closed loop control systems and patch pumps which continue to improve exponentially with access limited only by the availability of funding and patient preference. However, despite this, overall diabetes control has not improved significantly and certainly has not recovered from the remote reviews of the Covid years (Diabetes in Scotland, 2023). Contrast this with the lack of progress in diabetes foot care over the same 30-year period and you will see how my title and the reference to some things will never change still applies.

Diabetes footcare is estimated to cost the NHS around £1billion per year (Kerr et al, 2019). Unfortunately, the overall healing rates for diabetes foot ulceration appear to be stuck under 40% at 1 year and late referrals are still all too frequent (Guest et al, 2018; NHS England, 2024). The prevalence of foot ulceration is around 2% but as the diabetes population grows the numbers of ulcers and, ultimately, amputations grow (Scottish Diabetes Survey, 2023). The false dawns of growth factors, skin substitutes and the wider use of negative pressure therapy came and went. Even with the attempts of some dressings companies to perform actual randomised control trials with demonstrable treatment effects, we still do the same things. Foot care relies on offloading (successful to a variable extent often due to patient factors), debridement (determined by individual skill) and infection control (harder with increasing resistance patterns). Revascularisation is our fourth pillar of care but most vascular services have there own backlog making access more difficult.

How do we make more progress? I believe we need to:

- utilise more specialist diabetes foot services to standardise care and increase the referrals within 2 weeks of ulcer onset
- Use offloading devices that patients will accept rather than perhaps the

ideal method, which may be less acceptable to most
- Ensure that antibiotics are used only for clinically recognised infection and targeted by the best microbiological sample possible
- increase our links with vascular surgery and refer those patients with the best chance of improvement.

In our service, too many patients are seen in the last few weeks or months of life. Realistic medicine would suggest that interventions in this group are largely futile. Identifying these patients correctly and managing them less intensively would also free up spaces for those who are more likely to benefit.

Given the financial constraints facing the country and the UK NHS, we as clinicians are going to have to make choices about the scope of NHS care in so many fields. It may be that diabetes foot care could be more effective with better outcomes for many but perhaps not all. ■

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