# St Vincent – regret

**Matthew Young**
Consultant Physician, Royal Infirmary of Edinburgh, UK &
Editor-in-Chief,
*The Diabetic Foot Journal*

It may be presumptuous of me, but I suspect that few of the readers of this editorial will know the songs of Annie Clark, who performs under the name of St Vincent. I would, however, hope that most have heard of the St Vincent Declaration and its stated aim to reduce lower limb amputations due to diabetes by 50% within 5 years (WHO/IDF, 1990). This optimistic target was based on the pioneering first multidisciplinary diabetes foot care clinics of the 80s, particularly King's College Hospital, London, clinic led by Prof Michael Edmonds and the late Alethea Foster (Edmonds et al, 1986). They showed that a reduction in the number of major amputations was achievable by forming a multidisciplinary foot care team and providing a systematic approach to managing diabetes foot ulceration. Thirty-five years on, the mantra remains that the majority of amputations are preventable (Canadian Institute for Health Information, 2024), but in everyday practice, it does not feel that way.

There have been a number of studies suggesting that the incidence of amputations per 100,000 people with diabetes is decreasing in some regions but not in all (Canadian Institute for Health Information, 2024; Diabetes in Scotland, 2024; Hennessy et al, 2025). However, the reductions are certainly not approaching the levels of improvement proposed by the St Vincent Declaration or indeed the optimism of the early foot clinics. Why might that be?

The atlas of variation of healthcare highlighted marked regional differences in amputation rates in England (NHS Atlas, 2010). The most recent National Diabetes Footcare Audit (NHS England, 2024) reports that there are still significant variations between the highest and lowest rates of being alive and ulcer-free at 12 weeks. Similarly, the most recent National Diabetes Inpatient Audit (NHS England, 2020) reported that there are no diabetes footcare teams in almost one in five hospital trusts in England. As participation in the National Diabetes Footcare Audit is voluntary, those who do not participate may not have organised footcare teams and may even have lower healing rates.

As my last editorial discussed, the landscape of managing glucose control has been transformed in the 30+ years since I became a diabetes consultant, with new therapies emerging almost annually (Young, 2024). However, the treatment of diabetes foot ulceration has seen fashions come and go and remains essentially the same as it was when I first saw diabetes patients in Sheffield in the late 1980s. The number of people with diabetes has tripled over the past few decades. Most of this increase has been due to a rise in type 2 diabetes. Type 2 diabetes, in turn, is associated with increased cardio and peripheral vascular disease. The consequence of this is that whilst in the 1990s the majority of foot ulcers had a neuropathic aetiology, the proportion of dysvascular ulcers has steadily increased and they are now the majority in most clinics.

In addition, the diabetes population in general is becoming more obese, older and still smokes more than the non-diabetic population (Diabetes in Scotland, 2024). This is even more magnified in the diabetes foot clinic population. This, in turn, accelerates the development of peripheral arterial disease, renal impairment and has a significant impact on the likelihood of non-healing and the need for major amputation.

The mortality after amputation remains very high. Almost one in 10 patients will die within 30 days after a below-knee amputation(Hennessy et al, 2025). The highest proportion, not surprisingly, is in the elderly and frail. Patient selection and ensuring that patients with low prospects of survival are not subjected to a futile amputation would reduce amputation rates, but would require better palliative care to prevent unnecessary suffering.

Taking all the factors above, even modest reductions in the incidence of amputations are being overwhelmed by the inexorable rise in the number of people with diabetes, and regrettably, diabetes related amputation numbers are as high as they ever were. The optimism of the St Vincent Declaration is undimmed, but the potential remains unrealised. ■

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