Non-diabetes foot ulcer — is this Cinderella 2?

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In the 1980s, the term 'Cinderella of diabetes complications' was used in various guises and in many lectures and articles to describe how diabetic foot disease was viewed by the medical world. In 1986, Edmonds and colleagues were one of the first clinics to demonstrate with evidence that utilising a multidisciplinary approach to care of the patient with a diabetes foot ulcer has far better outcomes than an isolated practitioner approach to care (Edmonds et al, 1986). This was a pivotal moment and led to the first NICE guideline in 2004 — CG10 (NICE, 2004) — and subsequent iterations advocating a whole system approach to foot care, involving screening, foot protection and rapid access to multidisciplinary teams (MDTs). Although 20 years later Cinderella may not be invited to every ball, she has a much better chance of an invite and checking that her footwear fits!

In 2018, I co-authored an editorial in this journal entitled 'Is diabetes a passport to specialist services?' (McCardle and Chadwick 2018), where we argued that people with diabetes and a foot ulceration had access to specialist services and a MDT that would benefit people who didn't have a diagnosis of diabetes and often had suboptimal care. It is clear that people who have a foot ulceration but do not have diabetes would benefit from all the elements required to heal a diabetes-related foot ulcer. This includes regular podiatric input for wound care/debridement and, importantly, offloading and medical support to manage underlying disease process and infection control, as well as vascular review for assessment and optimisation and orthopaedic/podiatric surgery for review. The wider team, including nursing, physiotherapy and orthotists, may also be required. The aim of the original editorial was to initiate thoughts and discussion about how health services can address this clear disparity of care, where only the diagnosis of diabetes gives a person a passport to better service. The recent publication by Guest et al (2020) has now identified a financial cost. In 2017/18 over 1 million people within the UK had an active lower-limb ulceration, which is a 37% increase of prevalence since 2012/2013 (Guest et al, 2020). The increase in prevalence has been linked to a substantial increase in resource consumption, with patient management costs increasing by 48% from 2012/13 to 2017/18.

In 3 years, has anything changed? Or do we have a Cinderella 2? On the frontline, it is clear the answer is no. There are some pockets of equitable care in the UK, with some examples highlighted recently by the All-Party Parliamentary Group for Venous and Vascular disease (APPG), and the recent English Diabetic Footcare Network (EDFN) conference in May. Interestingly, at the EDFN conference, Professor Edmonds, who wrote the original article around the invaluable role of MDTs in diabetic foot care in 1986, strongly advocated the need for the inequality in provision to be reduced. The 'Legs Matter' campaign — *https://legsmatter.org/* — has also been vocal in its support for reducing the inequality of provision.

There is momentum growing behind this cause and recognition that people without diabetes need this kind of care. The recognition of the problem by the APPG, Legs Matter and the EDFN do bring some hope. The recent publication of the National Wound Care Strategy (NWCS, 2020) has created a national guideline to address the issue with specific guidance on lower-limb ulcers. The NWCS lower-limb recommendations do not just focus on leg ulcers, but also provide a clear

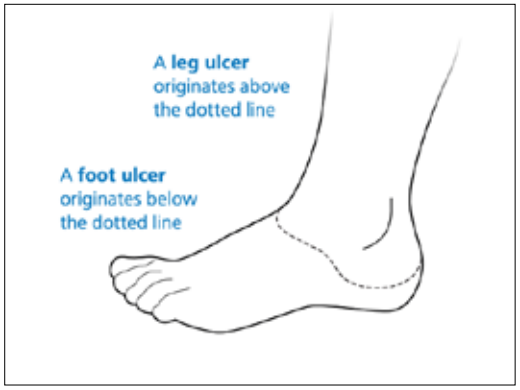

Figure 1: Guidance by the National Wound Care Strategy (2020) on the difference between a leg ulcer and a foot ulcer.

strategy for patients with foot ulceration. This has led to an agreed anatomical boundary line, helping clinicians to define a leg ulcer or a foot ulcer (*Figure 1*). Importantly, they also make the clear recommendation that when treating a person with a non-diabetic foot wound, "refer the person within one working day to the multidisciplinary foot care service or foot protection service". While this is guidance rather than policy, it develops the process and awareness-raising with policymakers and payers. The first implementation sites of the NWCS have a significant role in developing the models clinically to ensure equal provision.

There is clearly a need not to dilute our current diabetes foot provision, and further investment is required to improve the number of, and access to, MDTs. To quote our prime minister, we need to "level up" and bring up the service by investment and different service models.

Cinderella 1 was created in the 1980s and she is only now getting to the ball. The recent NHS long-term plan (NHS, 2019) identified that all patients with a diabetes-related foot ulcer should have access to an MDT. Let's keep working, so we are not waiting 30–40 years to see Cinderella 2 (non-diabetes) foot ulcers having the same provision. ■

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