I die, you die

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A single from Gary Numan's last number one album until his renaissance in the past few years might seem like an odd title for this editorial. However, the certainty of death (and taxes) is ever present for all of us, and for patients with diabetic foot ulceration, it is imminent.

My clinic in Edinburgh was one of the first to report that intensive cardiovascular secondary prevention strategies could significantly reduce 5-year mortality in patients with diabetic foot ulcers (Young et al, 2008). This was followed by a similar paper from the Faglia group in Milan suggesting that combining ACE inhibitor and statin therapy, standard cardiovascular risk reduction therapies, would reduce mortality from diabetic foot ulceration by 55% at 2 years. There was then a flurry of activity and articles promoting cardiovascular risk reduction for foot ulcer patients. However, rather like Gary Numan's reduced popularity in the 1990s and 2000s, things moved on and the focus of care on cardiovascular risk reduction waned.

It would seem that things are no better today than they were then. There have been two large series of foot ulcer patients reported in the past few years which continue to show that around half of all foot ulcer patients will be dead within five years of their first foot ulcer. This is the same as we reported in 2008. Heald et al reported a longitudinal series of patients from the Salford Royal foot clinic (Heald, 2024), and Chen et al reported a review of 34 studies including 124,000 patients (Chen et al, 2023). In both these series, the most common cause of death was cardiovascular disease. In our study it was 70%.

Why might this be? The National Diabetes Footcare Audit reports a number of parameters related to the quality of diabetic foot care in England (NHS Digital, 2026). One of these is the provision of blood pressure and lipid-lowering therapies. Only 50% of the patients in the audit achieved their lipid and blood pressure targets. We are therefore still failing to maximise our patients' chances of survival. As both our study and the Faglia study were cohort studies rather than true randomised controlled trials (RCTs), it has been proposed that a multicentre RCT, the MiFoot study, should be performed to finally answer whether such interventions have an effect (Onuwe et al, 2025). Until then we need to be mindful of the need to optimise cardiovascular risk reduction, and the article by Beale and colleagues in this edition of *The Diabetic Foot Journal* describes in detail the rationale behind lipid-lowering therapy and the current options for lipid lowering therapies. However, it is important to also know that antiplatelet agents and blood pressure targets, including the use of renin angiotensin system blockade (ACE inhibitors or sartans) and beta blockers, are also key components of an intensified approach. Perhaps we need an article about them too.

References

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