

# Antibiotics and the diabetic foot: What does consensus really mean?



Matthew Young

Scotland has a separate health system to the rest of the UK, one which is still largely centrally controlled. For this reason, national priorities are easier to decide and implement.

Approximately 2 years ago, diabetic foot care was made a national priority for funding by the Scottish Diabetes Group, which set up a Foot Action Group, under the chairmanship of Graham Leese, who appointed Duncan Stang as National Foot Care Coordinator for Scotland. A foot screening programme was the first target met. Other advances include developing a national competency framework for all levels of diabetes foot care and, over the past 6 months, developing a consensus document on antibiotic management for diabetic foot ulceration, published in this issue of *The Diabetic Foot Journal* (pages 62–78).

I have been involved in diabetic foot care for 20 years. Over this time, no issue has divided foot care specialists more than antibiotic therapy. The inability to determine reliably whether the foot is infected is just the beginning. Decisions on whether to treat or not to treat and, if the decision is taken to treat, then with what?, and for how long?, are difficult and often personal questions. Sadly, no randomised controlled trials (RCTs), in the true sense of the phrase, addressing these factors exist.

Older antibiotics will never be trialled. Most new antibiotics are compared against “standard” regimens, typically in non-inferiority trials, which rarely say anything other than antibiotic X will treat infections no worse than antibiotic Y, but as there are no “standard” regimens in practice such studies are rendered worthless. Indeed, the number of participants

required for a true RCT to determine, for example, the correct duration of treatment, would be so large that even centrally funded research bodies would struggle to afford such a trial, even if a protocol could be agreed upon.

The rise of so-called “superbugs” (e.g. methicillin-resistant *Staphylococcus aureus* (MRSA) and vancomycin-resistant enterococci), and concerns over infections acquired in clinics and hospitals (e.g. *Clostridium difficile*), have made newspaper headlines and cost patients’ lives, and hospital managers and health ministers their jobs. Infection control policies are getting tougher, and tighter antibiotic policies go hand-in-hand with stricter infection control. Many of the antibiotics traditionally used to treat the infected diabetic foot (e.g. co-amoxiclav, clindamycin and ciprofloxacin) are shunned by microbiologists as they are believed to cause laboratory, and possibly clinically relevant, rises in MRSA and *C. difficile* infection. However, to my mind, these issues are much less pressing in the typical outpatient setting of the diabetic foot clinic than they are for inpatients.

In the absence of RCT data, expert opinion and consensus are the best tools for developing a cohesive policy in this area. The antibiotic guidance presented here is a consensus statement from the Scottish Diabetes Group and the Scottish Infectious Diseases Society, developed by diabetologists, infection control specialists and microbiologists from Scotland and England. It is not perfect – some antibiotic choices need to be adapted for local resistance and usage policies – but it is a practical document, drawing on a wealth of experience, and provides guidance that can be used across primary, secondary and tertiary diabetic foot care settings on a daily basis. ■

Matthew Young is a Consultant Physician and Clinical Lead, Diabetic Foot Clinic, The Royal Infirmary, Edinburgh.