Foot forum

In association with Foot in Diabetes UK

The idea of the Foot forum is to disseminate some of the discussion threads generated on the Foot in Diabetes UK (FDUK) Internet discussion forum to a wider readership. It will also act as a noticeboard for important announcements for healthcare professionals involved in the care of people with diabetic foot problems. If you wish to contribute with a question, an answer to a question or an important announcement please email manish@sbcommunicationsgroup.com.

Presenting group education

Q. Has anyone had any experience of presenting a group education session on diabetic foot care? If so how did those who attended respond? What sort of feedback did you get?

Adam Smith, Podiatrist, Melrose

A. A colleague of mine set up specific talks in Hindi and Punjabi to target high-risk Asian people. All who attended were given an evaluation form at the end of the session. At the same time, many of those attending also used the session to ask about controlling blood glucose and requested dietary advice. I would recommend that you have pathways to refer to other healthcare professionals in case this happens. I have previously done joint sessions involving a dietitian, a DSN and myself; each talking for around 20 minutes each. Here in Birmingham we also have group education sessions where all of these aspects are addressed in one session by a health educator. If you are starting from scratch then prepare something and give the presentation to a group of people (peers at a staff meeting or ask some people from a clinic), receive feedback and then re-evaluate and continue from there.

Mike Green, Community Chief III Diabetes Lead Podiatrist, Heart of Birmingham tPCT

One-stop shop for screening

Q. How many services out there have joint one-stop retinopathy and foot screening services? In Wales we have a retinopathy screening service that has now been adopted throughout most of Wales, but there is joint screening in only one area. Does anyone have any information regarding the success or failures of such schemes? We are currently training primary care professionals to screen for foot problems, which, even with a one-stop approach, would still be beneficial in being able to target those who fail to attend specialist clinics.

Scott Cawley, Lead Specialist Podiatrist, Cardiff

A. The Western Isles Health Board has initiated a joint retinopathy and foot screening project – I would recommend getting in contact with Sarann MacPhee. My area has recently introduced a locally enhanced service where general practice gets further payment for managing people with type 2 diabetes that do not require insulin and in whom macroproteinuria is not present. This includes foot screening for those who have already been identified as low risk. Additionally, we have a retinal camera at our main hospital and one in a van that goes out to GP surgeries in the localities. With hindsight, it would have been worth discussing combining the services.

Sandra Jones, Diabetes Clinical Lead Podiatrist, Trafford PCT

Deroofing of blisters

Q. I recently saw an individual with diabetes who had a very large blister on his medial arch. I was unsure whether to deroof or let the blister burst itself. In the end I opted for the latter and covered with a dressing. What would other people do in this case?

Name and address witheld

A. It is always a difficult deciding whether to intervene or not. My experience has been that if the blister is very turgid, if it has been present for more than 3–5 days then intervene regardless of size. I would do this simply because of the high pressure on the capillary bed beneath the blister which can quickly lead to deeper tissue damage and subsequent ulceration. If the blister is flaccid then it tends to suggest that tissue fluid is being reabsorbed and it is resolving. In this instance one has to decide whether to apply tensile force over the blister to aid resorption or to let things be. Just as a practical tip, I tend not to deroof blisters on the whole but aspirate them, leaving the blister roof present with a small amount of fluid in situ. This is for several reasons but mainly to control portals of entry for bacterial invasion. It leaves two small holes rather than removing the whole blister floor. Also, it leaves an anti-frictional layer in place.

Neil Baker, Diabetes Research Podiatrist, Ipswich

Options for persistent ulcers

Q. We have a few people in their 50s and 60s who were relatively active prior to suffering from a foot ulcer which has since persisted for 6–24 months. We have the patients in various casts with generic advice to rest and minimise unnecessary weight-bearing activity for the duration of their ulcer and for some time after healing is complete. With the treatment options of pressure relief, rest and medical management, are we inadvertently increasing their risks of myocardial infarction, cerebrovascular accident or related death by trying to save them from amputation? Would we be helping patients more if, after a foot ulcer has failed to heal at 3–6 months, we at least explored the surgical option of an elective below-knee amputation, with prosthesis, rehabilitation and cardiovascular exercise? Or, if amputation is not an option, continued medical management with an exercise prescription that does not put excessive pressure or friction on the ulcer site? Is anybody looking at cardiovascular risk factors in their chronic foot ulcer patients and able to give me some guidance or an opinion on this issue?

Martin Fox, Clinical Lead Podiatrist, Tameside and Glossop PCT, and secretary of FDUK

A. Here are the answers I would give to his three questions: yes, yes and yes.

The first question is concerned with whether or not younger, more active people with increasingly chronic ulcers should be offered definitive elective surgery, including major amputation. Yes; I think we would all agree that they should and that an open discussion of all of the management options should be a part of regular consultations. In the end, it is largely up to the patient to decide which of the available options they would prefer.

The second question is to ask whether or not we should be offering pre-emptive exercise and rehabilitation in the routine care of people with chronic foot ulcers. This makes sense and we should certainly be thinking of it more than we do at the moment. It would be interesting to know how many specialist units routinely include assessment and intervention by a physiotherapist or an occupational therapist and whether or not any work has been done to demonstrate their effectiveness. A quick search of PubMed did not identify anything of particular relevance but if there is such evidence available, then these services should be provided by more. However, there can be barriers. In our hospital, we are not able to refer outpatients for physiotherapy: the request has to be submitted by their GP (for reasons that are concerned more with cost restraint than clinical care).

The third question concerns the assessment of cardiovascular risk. The point is well taken because the person with a foot ulcer often has multiple complications of diabetes and may well be at an increased risk of early cardiovascular-related death. This means that we should all be thinking of related issues such as cardiovascular risk, and routine screening in the specialist foot service is certainly an option to address this. To my mind, it does not make much difference which tests are used; and the simplest (smoking habits, blood pressure measurement or cholesterol assessment) are probably the best. I would not endorse the annual measurement of ABPI in diabetes as a measure of cardiovascular risk; which is currently recommended by the American Diabetes Association (ADA, 2003; Jeffcoate and Game, 2006). In practice, however, the majority of individuals already have their cardiovascular risk assessed on an annual basis by their GP or hospital team and there are few people with diabetes (who are in the foot-risk age range) who escape routine prescription of aspirin, ACE inhibitors and a statin. In fact, it would be better for some if they did but that is another issue!

I suppose the overall answer, as always, is that we should, as Martin says, remember that our task is not to manage the foot ulcer in isolation, but to manage the person to whom the ulcerated foot belongs. It is for that reason that we – podiatrists, nurses, physicians, surgeons and other therapists, in both primary and secondary care – should all work more effectively together to ensure that every person with diabetes has ready access to all of the clinicians and their skills that the individual requires (Diabetes UK, 2006; Stuart and Jeffcoate, 2007).

William Jeffcoate, Consultant Diabetologist, Nottingham

ADA (2003) Peripheral arterial disease in people with diabetes. *Diabetes Care* **26**: 3333–41
Diabetes UK (2006) *The National Minimum Skills Framework for Commissioning of Foot Care Services for People with Diabetes*. Diabetes UK, London
Jeffcoate WJ, Game FL (2006) Should annual measurement of the ankle-brachial index be routine practice in diabetes care? *Nature Clinical Practice. Endocrinology and Metabolism* **2**: 540–1
Stuart L, Jeffcoate W (2007) Long-awaited formula for the improvement of foot care in diabetes. *Practical Diabetes International* **24**: 122

Cleansing of diabetic foot ulcers

Q. Should cleansing be carried out before swabbing of diabetic foot ulcers? We have asked for clarification from senior biomedical staff, but no clear response has been forthcoming. Current practice is that we do not cleanse before swabbing, as presumably it would defeat the purpose of swabbing. However, we have come across literature in a search suggesting that the wound should be irrigated with normal saline before swabbing. What do others think?

Adam Smith, Podiatrist, Melrose

A. I am going to be contentious here and say do not swab – take tissue, however, if feel that you would rather swab then make it as deep as possible. Our practice here is that we do not clean any wound before microbiological specimens are taken for the reasons you state. Additionally we do not clean any of our wound beds except by sharp debridement.

Neil Baker, Diabetes Research Podiatrist, Ipswich

What is a foot ulcer?

Q. According to the recent issue of *The Diabetic Foot Journal* (Burnside et al, 2007), many people do not understand what is meant by the term 'foot ulcer' which can clearly cause problems when dealing with people with diabetes and their families. How do other people explain what an ulcer is?

John McCall, Podiatrist, Ayr

A. I would say that a definition of a foot ulcer is 'a break or disruption of the epidermis on the foot, which may be masked by nail, callus or blisters, including breaks in the skin caused by nail penetration'. Add the diagnosis of diabetes and you have a diabetes-related foot ulcer. I think a classification system is very useful for multidisciplinary triage and communication tool across podiatrists, nurses and doctors in both the hospital and community settings. The TEXAS system does it very well, if taught properly. I often combine TEXAS with the Lipsky et al (2004) definitions of severity, once infection is suggested, to aid decision making regarding treatment or referral in any location. I still have no idea how to help a person with diabetes gain a true understanding of the term 'foot ulcer', but I often start by telling them that it is ' a hole in your foot, linked to diabetes damage, which can let bugs in and can result in you losing your leg if we don't work together to heal it up'. I think pictures without clear explanations are misleading and can be a badly used tool if not used at the right time in the education of the person with diabetes. Ultimately we are entrenched in our own particular practice and beliefs and I think the article mentioned above should be a wake up call around using the term 'foot ulcer' with those who do not understand it.

Martin Fox, Clinical Lead Podiatrist, Tameside and Glossop PCT, and secretary of FDUK

Lipsky BA, Berendt AR, Deery HG et al (2004) Diagnosis and treatment of diabetic foot infections. *Clinical Infectious Diseases* **39**: 885–910

Which antibiotics?

Q. I read with interest the recent article in *The Diabetic Foot Journal* by Matthew Young regarding the management of infection. In our PCT we are looking at developing guidance for GPs on initial prescribing for mild to moderate diabetic foot infections and tying it in with referral to the diabetes teams for further management, as per NICE guidelines. Our early draft has suggested that for mild infections we use fluclox 500 mg 1 g QD or; fluclox 500 mg 1 g QD plus amoxicillin 500 mg TID (or; erythromycin 500 mg BID if the individual is hypersensitive to penicillin). For moderate infections, we will use co-amoxiclav 375 – 625 mg TID. My question is this: in light of the article, should we also include an option of co-amoxiclav at 375–625 mg TID for the initial management of mild infections? Some GPs I have discussed it with would prefer it instead of the fluclox plus amoxicillin option. I am inclined to propose that we include it.

Martin Fox, Clinical Lead Podiatrist, Tameside and Glossop PCT, and secretary of FDUK

A. My problem is with the terminology; does a 'mild' or 'moderate' infection actually exist? Either there is an infection present or there is not. I would have thought that the key to prescribing the appropriate antibiotic (other than knowing what the pathogen is, obviously) is identifying whether the infection is localised to the immediate surrounding area and superficial, or whether it is deep and penetrating to bone. The question would therefore change to: are oral antibiotics indicated or does the patient require an IV? In the case of oral antibiotics, is there any osteomyelitis present? Linking prescribing to the TEXAS classification grid is also potentially useful. We have resolved many cases of osteomyelitis at the Victoria Infirmary in Glasgow with clindamycin (or sometimes fucidic acid plus fluclox). We found that this was particularly successful when used in classic swollen digits. Our percentage of osteomyelitis was quite a bit higher than the 20% quoted from Edinburgh in the recent paper by Matthew Young, probably owing to the late referral of foot ulcers to our clinic (which was only established in its multidisciplinary form in 2002) and the time it takes to change referral habits! I think co-amoxiclav is a useful first-line treatment for superficial lesions, but we tend to use high doses of fluclox.

Keith McCormick, Diabetes Podiatrist, Victoria Infirmary and Clinical Teacher, Southern General Hospital, Glasgow