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 editorial@sbcommunicationsgroup.com.

Week-long clinics

Q. Our foot team works across the community and hospital settings but our hospital clinic, which is consultant-led, is only available for two sessions per week. We see all other patients in the community and have rapid access to the hospital according to defined criteria. I know that some of my colleagues provide a 5-day service with access to a multidisciplinary team clinic. I would be very interested to know how many provide hospital multidisciplinary team-based clinic access for foot patients 5 days per week.

Louise Stuart,
Lecturer/Practitioner, University of Salford

A. Our hospital clinic will see foot patients on Mondays, Tuesdays and Wednesday all day and up until 3 pm on Fridays. Thursdays are used for administration purposes, but emergency sessions are feasible without a formal clinic.

A shoe clinic is held every Tuesday morning; however, patients can also be seen in the general orthotic clinics and the orthopaedic hospital for issues surrounding CROWs (Charcot Restraint Orthotic Walker) and similar. The foot service is run from a diabetes centre that has four inpatient beds.

Individuals with vascular complications are admitted to another hospital situated one mile away if emergency surgery looks to be likely. Email, digital photography and phone calls comprise the core of the service as many specialists in orthopaedics, bone infection, revascularisation, dermatology and limb fitting are not available on site but are accessible at sites within a mile radius. The same is true for resources such as plaster rooms.

Community podiatrists, GPs and nurses can get people seen in our clinic either on the day of referral or the following day. However, the service requires a fax be sent through beforehand to keep the Clinical Advisory Liaison Service informed (used to prevent unnecessary referrals). At weekends the recommended pathway is through A&E or an on-call service at the diabetes centre.

Hospital podiatrists run outreach clinics in the community and feed individuals with diabetes back and forth. However, there are not enough staff in the community to run clinics as often as we would like. This is all not perfect and has had to evolve with changes in the NHS. My wish list would include more community outreach clinics, weekend and out of hours cover and a podiatrist in the hospital A&E department.

Name and address withheld

Hunting for promotional posters

Q. I am looking for useful sources where I can obtain posters and pictures for health promotion displays. Last week we had a diabetes public event and some of our posters for the display are looking tired so I want to replace them, but do not know where to start.

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

A. National organisations such as the Society of Chiropodists and Podiatrists would be a good place to start, as would Diabetes UK. Some of the best posters and images tend to be provided commercially from such companies as Algeos, Eli Lilly and GSK. Pfizer have also been known to produce some good materials addressing neuropathy.

Name and address withheld

At risk of abusing services?

Q. Recently I participated in a debate into the issue of risk identification. NICE describes being 'at-risk' as having neuropathy, peripheral vascular disease or other risk factors (the full list being extensive and including duration of diabetes, age, sex, smoking, oedema, etc).

We, at Salford PCT, would not take an individual into our foot protection programme who did not have neuropathy or peripheral vascular disease but did have some of the other listed risk factors. Some of the other services available would act differently – this, I feel, would defeat the purpose of screening for risk factors such as neuropathy and peripheral vascular disease.

While I feel things like foot deformity are important, we run the risk of identifying every case as 'at-risk' and swamping services. I would be very interested in hearing what other people think on this issue.

Name and address withheld

A. I would agree that there has to be a cut-off point in who should be included in your foot services. You are using your evidence base, which states peripheral vascular disease, neuropathy and history of ulcer or amputation are the biggest risk factors for ulceration. If you looked at every adult with diabetes, you can be pretty sure that there will be at least one associated risk factor such as smoking or old age, for example.

However, as everyone is meant to be screened annually, the primary screener should also be able to give basic advice regarding foot care. Would you count this as including them in a foot care service? If there is a potential problem highlighted by a primary screener, the person with diabetes moves up the care ladder and foot care advice will then be tailored towards their individual needs.

I think you are absolutely right that you do not want every person with diabetes to be referred to your team as this would be a totally inappropriate use of your team's skills. I suppose the whole issue goes back to educating the healthcare professionals to help them understand that a person with diabetes does not equal a person that will definitely have foot problems and needs specialist podiatric care. Those that do ulcerate are actually a small percentage of the overall diabetes population.

In conclusion, I think you should stick to your instincts!

Joanne McCardle, Diabetes Specialist Podiatrist, Edinburgh

Missed appointments and learning difficulties

Q. What are your policies and those of others with patients who have learning difficulties who are persistent non-attenders and are hugely difficult to contact in writing. We have three such patients at the moment who have active osteomyelitic ulcerations and management is proving a huge challenge.

Louise Stuart, Lecturer/Practitioner, University of Salford

A. Those who are either old, incapable of making their way to clinic or have learning difficulties are on our list for patient transport. There are still some who will not 'comply' and tell the ambulance to go away! However, for every appointment in the ulcer clinic, a letter is generated to the GP detailing patient treatment and any incidence of continuous non-attendance. This enables the GP to recognise non-attendance and put in place care to assist the relevant individuals who do not attend appointments. Also, I have found that for those who have daily nurse input, e.g. for daily insulin injections, this contact can be used as a means to help get them to their appointments.

We are currently doing an audit on non-attendance rates and data thus far shows it to be surprisingly (and refreshingly) low. I think this is aided by the provision of transport for which patients simply have to be ready for pick up at a specified time. I think the best way to encourage attendance is to liaise with the other professionals that look after these individuals, and work towards encouraging them to make their clinic times. Easier said than done, though!

Joanne McCardle, Diabetes Specialist Podiatrist, Edinburgh

Any answers?

Email: editorial@sbcommunicationsgroup.com

Prevention of apical ulceration

Q. We are seeing the same two individuals each month in a failing attempt to prevent recurrent ulceration. Currently, silicone props are being used on one with some success. However, the second individual refuses to wear them – she is neuropathic, in no pain, and does not feel that there can be anything wrong with her feet. She is using a high-urea-based cream, which has massively reduced the incidence of ulceration, but it still occurs periodically. Does anyone have any suggestions for prevention of apical ulceration?

Anna Evans, Community Podiatrist, Suffolk PCT