Extending the scientific basis of diabetic foot care

William Jeffcoate

Table 1. Challenges.

Challenge 1
Will Edinburgh and Nottingham do a prospective, head-to-head (or 'foot-to-foot'?) comparison of outcome to determine if the difference in healing rate is real and, if so, why? If anybody else wants to join in, please let me know.

Challenge 2
Will interested manufacturers sit down with a group of us and agree on an ethical programme to advance knowledge on the optimal management of chronic wounds in diabetes?

Following the writing of this editorial,* The Diabetic Foot *has decided to set up formal discussion between healthcare professionals and industry to start the process of progression. We will report on this in the next issue.

Alistair McInnes (Editor) and Matthew Young (Associate Editor)

William Jeffcoate is a Consultant Endocrinologist at City Hospital, Nottingham.

No one can dispute the general theme of Matthew Young's editorial comments. All of us agree that there is a dearth of hard evidence to substantiate everyday practice in the field, and that such evidence is needed if the quality of management of the diabetic foot is ever going to be dragged into the 21st Century.

The danger of believing that professional dogma is right

OK, we accept that the absence of trial evidence does not necessarily mean that what we do is wrong. But that is not the same as allowing ourselves the liberty (arrogance?) to believe that what we do is necessarily right. Expert opinion is acceptable when there is nothing else available, but it is a poor substitute for science. We should strive continually to obtain the evidence that is needed – even to substantiate the things which we take for granted.

Why the trials have not been done

To Matthew's four points I would add a fifth: perhaps the dominant reason for the lack of trial evidence is that many healthcare professionals don't like feet, and especially not manky feet. Furthermore, many people out there – including those in what might be called 'mainstream diabetes' – do not focus on the diabetic foot as a major problem. It is much more academically flash to fiddle about looking for candidate genes for this, that and the other than it is to think about what can be done to improve the lot of people who may be facing loss of a limb.

Education

The data are very thin and the evidence from the oft-quoted papers is poor. There is a desperate need to substantiate the role of education (Who teaches? What? How? To whom? How often?). Indeed, it is depressing that health authorities and primary care trusts feel under pressure to implement (largely opinion-based) National Institute for Health and Clinical Excellence guidelines on foot care education without any form of cost–benefit analysis. In my opinion, it would be better if this money was invested in employing more podiatrists, providing more effective and accessible orthotic services and initiating greater coordination of care of established ulcers between community and hospital.

Metabolic control

I was impressed that the overall healing rate in Edinburgh is 85%. We know ours is only 69.7%, and I fear that although we have a diabetes specialist nurse in the foot clinic, the overall level of glycaemic control is pretty poor. Hence, I think we need some more detail. And that is why I am issuing Challenge 1 to Matthew Young (*Table 1*).

Dressings

I have always been aware of the mutual benefits of the symbiosis between the National Health Service and the pharmaceutical industry. If it was not for commercial sponsorship, for instance, we probably would not now have any postgraduate medical training at all in diabetes. But in the case of dressings, I am wondering whether we could develop the relationship. And so I propose Challenge 2 (*Table 1*). Can we work with dressings manufacturers to establish the evidence base needed in our field in order to improve the outcome for people suffering the consequences of this dreadful complication of diabetes?

Collaborative research

Yes! I couldn't agree more. It is no longer possible for the individual clinician to advance knowledge while armed with nothing more than determination and a good idea. The hurdles of governance are such that researchers now need full-time support staff to cope with 'research Rottweilers'. We all therefore need to share resources, and we hope that CDUK (which has just gone live; see page 57) will prove to be the first of a new wave of related studies. There is much to be done and we will achieve it more quickly if we do it together. ■