An evidence base for diabetic foot care: A step forward?

Matthew Young

A lot has been going on behind the scenes after William Jeffcoate and I wrote editorials for the last edition of *The Diabetic Foot* journal. We both lamented the lack of evidence that underpins the practice of caring for people with diabetic foot problems. Also, we both recognised that to create a true evidence base would require hundreds and possibly thousands of participants. The number of variables, such as ulcer site and size, vascular status, infection risk, number of off-loading methods and scope of infection and colonisation, together with the range of anti-infective agents make for a bewildering choice. This does not include any thought of how to prevent ulceration or treat Charcot neuroarthropathy. With such a choice how do we decide which trials to prioritise and how to standardise protocols and still make them yield meaningful results within realistic clinical scenarios and timeframes? The answer is that, without a formally organised trial and enough finances, many of the studies we would like to do are going to remain unfulfilled dreams. Therefore, we need a different way; a better way?

A call to arms

Each of us, sadly, work in isolation or small teams and yet we all generate lots of information. We record patient demographics, ulcer characteristics, treatment plans and outcomes. One centre can only make so much of a statement: 'This is what we do and these are our results'. William challenged the Edinburgh team to compare its outcome data with those from Nottingham, our independently audited and published results being so incredibly (incredulously?) good. I am happy to stand by them. I am also willing to call upon centres up and down the UK to join in this quest. Put enough people together and collate all of their information and there is a potential to mine it for nuggets of useful data on which treatments work, how, and why.

It is postulated that there are varying outcomes between centres. If we can establish that such differences exist then we can start to work on why they exist. Is it standardised care, is it organisation, or are there other factors?

An even more interesting scenario might be that if we determine there is no meaningful difference between centres once case mix is accounted for, then treatment regimen, within limits, does not really matter. What then accounts for the national spread in amputation rates?

A call to industry

I wrote in my last editorial that it is unlikely any one pharmaceutical company or dressing manufacturer would be able to afford to pay for the major trials required to establish true efficacy for therapies, including antibiotics in diabetic foot patients. Statins for cholesterol are high-earning, high-profile drugs; foam dressings do not have the same kudos and the choice is even greater with lower profit margins and a shorter product life. Comparative trials of drug versus drug are rare and, therefore, trials comparing one type of dressing with another are extremely rare. A similar multi-centre audit recording treatments for ulcers, dressings, antibiotics and adjuvant therapies would possibly reduce the need for randomised comparator studies, as case controlled groups could be formed from large enough patient populations.

The possibilities are endless. Limited only by the imagination, dedication and a relatively small amount of finance.

A call for alms

In the modern NHS there is often little time and money for meaningful, continuous large-scale audits. I would ask whether drug and dressing companies are willing to pay a contribution of their education, training, research or even marketing budgets towards a national, centrally co-ordinated data centre. This would possibly be based and administered through a sub-committee of the board of *The Diabetic Foot* journal. This payment would help run the central offices and each participating centre could have a sessional payment to ensure that they submit their information. This would ensure the data is collected, interpreted and then the results published to a wide audience, i.e. you, the 15 000-plus readers of this journal, committed to improving diabetic foot care wherever you are. ■

We would welcome your views on these proposals and expressions of interest in possibly participating in this project. I believe that we could be on the edge of something truly great. I hope you agree. Please write to* The Diabetic Foot *journal.

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