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.

Bone removal

Q. Where a bone protrudes above the level of the skin and is obviously delaying the healing, I have no problem removing fragmented diseased bone in the area but not when the bone is intact and not clinically infected. How long should we wait to see if it shows signs of healing? Are we then increasing the risk of infection or, even worse, amputation, or should we refer straight away for bone clipping by the surgeons? Where no infection is apparent, should we use prophylatic antibiotics or topical dressings to prevent bone infection? We now have a clinic where we have direct access to the vascular surgeon who is quite happy to clip this bone.

Scott Cawley, Lead Specialist Podiatrist, Cardiff

A. At the Royal Infirmary in Edinburgh we (both myself and the podiatrists in the team) would remove this bone using bone rongeurs. Cutting the bone below the skin surface would usually allow closure. If this fails, surgeons are available to help but are rarely, if ever, needed. Bleeding can occur if the bone is still viable but this is readily stopped. This may seem radical but is based upon years of experience and practice: if the bone is left it will become infected and the foot will get worse. We also use antibiotics, such as clindamycin, to reduce the degree of infection in such cases.

Joanne McCardle, Diabetes Specialist Podiatrist, Edinburgh

Young people with diabetes

Q. I am trying to sort out our local approach to young people with diabetes. Has anyone ever seen diabetic vascular or neuropathic complications in children's feet? What is the thinking on preventative education for children and parents? At what age should we start screening? What is our role at paediatric diabetes clinics? My thoughts are that we should target parents and children with basic footcare education as part of an education programme and that we do not need to screen under 12-year-olds. However, I can't find much evidence, if any exists. Could you point me in the right direction?

John McCall, Podiatrist, Ayr

A. I have experience of a 14-year-old with retinopathy and painful neuropathy. The painful neuropathy resolved with improved control; however, I am not aware of the outcome of her retinopathy. Additionally, I have two children (now 21 and 17) who were both diagnosed with diabetes at 3 years of age. My personal feeling is that diabetes is degenerative, so catch children as early as possible and educate patients and parents in order to make them familiar with screening tools at a young enough age to dispel fear. Louise Stuart has done a tremendous amount of work in this area.

Sandra Jones, Diabetes Clinical Lead Podiatrist, Trafford PCT

Coercion or care?

Q. When a patient takes off a foot device, and we put them in a completely non-removable cast, have we gained his or her informed consent for this? Are we coercing or abusing them? Ultimately, is the individual's decision to remove a cast their own choice? Is it that they want to risk amputation rather than wear the cast? Or is it due to a failure on our part to communicate the risk in a language they understand?

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

A. The issue of adherence or concordance is only possible if they agreed to it in the first place. When patients often agree to casting they are unsure as to what limitations this might put on them and then take them off when it hits home. We know that total contact casts limit people to around 500 steps a day, so is it a surprise that if they can be removed they will be? As practitioners we need to understand patients' agendas so we can tailor our treatments of casting accordingly.

Scott Cawley, Lead Specialist Podiatrist, Cardiff

Patient-held records

Q. In a clinical effectiveness meeting there was a debate about the merits of providing the patient with a copy of their care pathway in writing. In support of this was the theory that when a referral slips through the net the patient would be in a position to detect that something was amiss. How many of us use patient-held records or provide the patient with a copy of their proposed care pathway? In my region we are being encouraged down the single patient-held record system. What are people's thoughts and current practice with regard to this?

Name and address withheld

A. At Trafford PCT we have used patient-held records for our diabetic foot ulcer patients for a number of years now: our documentation is in duplicate with one copy for our records and one for the patient's. The documentation was set up in conjunction with the clinical nursing lead for community at the time, as the idea was that the paperwork would not be podiatry led and therefore would be truly multidisciplinary to encompass a joint management plan for the patient.

This system seems to work quite well at empowering a lot of people to take a more active role in their management; however, the main problem we encounter is that between podiatry reviews the district nurses or practice nurses are not keen to fill in the multidisciplinary documentation and record in their own notes only. We set up a working party roughly 18 months ago consisting of members of the district nursing team and podiatrists in an effort to address and rectify the problems identified. Unfortunately, the uptake for this was very poor and circumstances have not greatly changed. The main sticking point was not that the district nurses did not feel involved with the process, but that they felt it was simply one more piece of paperwork to add to their load, and therefore their own records come first.

Getting around this is another problem entirely, and one which much effort and liaison has gone into already but to no avail.

Louise McDaid, Diabetes Clinical Lead Podiatrist, Trafford PCT

Auditing for training needs

Q. Does anybody have any suggestions for where I can find out about the process of critical event or incidence analysis for diabetic foot ulceration and amputation? I saw Paul Chadwick's article in *The Diabetic Foot* (**9**[2]: 66–74), but would like more information on how to go about actually auditing the ulcer and amputation cases in order to identify, for example, training needs.

Anna Evans, Community Podiatrist, Suffolk PCT

A. You might be able to tap into processes already in place in your PCT. Clinical governance leads or clinical risk managers may be interested in helping you set up the ulcer and amputation audit. If not, getting your manager and the diabetes or vascular consultants (or who ever does most of the local amputations) on board would be a good starting point. Be careful how you sell it – some people might be wary of why you are doing it and what it will show. It is a big, but important, project that should be part of all our diabetic foot frameworks, but I guess not many people are doing it yet.

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

Announcement from FDUK

The second FDUK Masterclass on the Diabetic Foot took place on 6 December 2006 at the Reebok Stadium, Bolton. This year's programme focused on off-loading the ulcerated diabetic foot. The day started with three theory-based talks providing a good evidence-based grounding for the masterclasses in the afternoon. Neil Baker (Research Podiatrist, Ipswich) and Robert Van Deursen (Senior Research Fellow, Cardiff) talked about the evidence base for existing off-loading techniques and how to decide which pressure relief methods are best suited for specific ulcer types. Martin Fox and Irene Yates (Clinical Lead Podiatrist and Tissue Viability Nurse [respectively], Tameside and Glossop PCT) presented a case study and discussed specific aspects of the individual's heel ulcer with the audience. The afternoon took the theory of the morning and allowed delegates to get hands-on experience in, for example, casting using modern materials.

Louise Stuart, Consultant Podiatrist, Manchester, and Chair of FDUK

Non-medical prescribing: Creating a prescribing list (P-list)

Q. I am at the stage of having created a wish list for future prescribing competencies for myself and my PCT. Using the BNF I have selected a range of relevant drugs and dressings from the cardiovascular, central nervous system, infection and skin chapters. However, for the sake of the non-medical prescribing course and my medical supervisor, I have been advised to choose 3–6 products for the duration of the course in order to become competent in their prescription. Bearing in mind that I will be working mainly with people with diabetes or peripheral vascular disease, should I go for, for example, 6 antibiotics, or 4 antibiotics and 2 drugs for painful neuropathy, or 3 antibiotics and 3 dressings? I would appreciate any discussion and guidance from those who have already put themselves through the course.

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

A. As a supplementary prescriber, my competence is in controlling infection and my formulary is for those antibiotics that we commonly prescribe in our foot clinic in accordance with our antibiotic guidelines. This was enough to concentrate on during the course. The idea is to then build on the formulary over time in order to gain competence around pain management and whatever else fits in with everyones practice as long as ability can be demonstrated. My advice is to start small. Supplementary prescribing is a safer and more appropriate framework for supplying medicines for both the service users and the practitioners.

Louise Morris, Diabetes Clinical Lead Podiatrist, Trafford PCT

Any answers?

Email: manish@sbcommunicationsgroup.com

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

Prevention of apical ulceration

Q. We are seeing two patients monthly in a failing attempt to prevent recurrent ulceraton. Currently, silicone props are being used on one with some success. However, the second patient refuses to wear them – she is neuropathic, in no pain, and does not feel that there can be anything wrong with her feet. This individual 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

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 tPCT