Foot in Diabetes UK: FDUK tool kit goes live!

A report from the *5th Annual FDUK Masterclass on the Foot in Diabetes*, which took place on 3 December 2009 at the Lancashire County Cricket Club, Manchester.

This year's FDUK Masterclass was based around a series of live demonstrations and videos, provided by experts in the field of diabetic foot care. The one-day event had a hands-on approach to diabetic foot care, and covered a range of topics, including amputation, revascularisation, triage, debridement, casting, diabetic neuropathic pain and developing gold-standard foot care services for all people with diabetic foot disease.

Simon Breed (Publisher, *The Diabetic Foot Journal*) and June James (Consultant Nurse, Leicester) welcomed attendees to the event. Simon congratulated FDUK on the 5th anniversary of its masterclass and lamented that the group's Chair, Louise Stuart MBE (Consultant Podiatrist, Manchester) was unable to Co-Chair the event with June as planned. Simon then introduced the first speaker, Brian Kennon (Consultant Physician, Glasgow).

Brian discussed people's perception of amputation of the diabetic foot as being a last resort, undertaken as an emergency procedure. However, he pointed out that around 11% of people with a diabetic foot ulcer will undergo an amputation within 12 months of ulcer onset (Jeffcoate et al, 2006), and that the risk of amputation is related both to the type of ulcer (Moulik et al, 2003) and that amputation risk maps onto the Texas ulcer classification scheme (Armstrong et al, 1998). Thus, Brian suggested, for some people with chronic, recurrent diabetic foot ulceration, a planned amputation, with the early involvement of a rehabilitation team, might enhance their quality of life.

Brian reported evidence that mobilised amputees have a better quality of life than people with active foot ulceration (Goodridge et al, 2005). However, he emphasised that the number of people who can expect a positive amputation outcome (i.e. remobilisation with a fitted limb) needs to be improved before amputations can be considered as a elective therapeutic option. Data from the Scottish Physiotherapy Amputee Research Group suggest that only 35% of people with diabetes have a fitted limb post-amputation (unpub. data, 2007).

Next, Mike Edmonds (Consultant Physician, London) presented a snap-shot of three people with diabetic foot ulceration who presented to his busy London clinic. Video footage was used to illustrate each foot at presentation, the process of triage in the clinic, and the podiatric and surgical interventions undertaken to manage the diabetic foot disease in each case. The final case that Mike presented was a man with extensive Charcot that had been undiagnosed by other healthcare services for a number of years. Mike reminded the audience that a hot, red foot is Charcot until proven otherwise.

Professor Cliff Shearman (Consultant Vascular Surgeon, Southampton) discussed the role of peripheral arterial disease (PAD) in the failure of diabetic foot ulcers to heal. Cliff stressed that the detection of PAD with bedside techniques is incredibly simple, but too

often neglected. Data from the USA (Berceli et al, 1999) and Finland (Winell et al, 2006) suggest that revascularisation reduced amputation rates, and Cliff encouraged the attendees to suspect any person with diabetes and a history of any cardiovascular symptoms of having PAD and to investigate accordingly.

The three primary methods of revascularisation used by surgeons are to dilate the occluded vessels (angioplasty), remove the obstruction(s) (endarterectomy) or bypass them. Cliff presented video clips of these procedures, and reminded the audience that angioplasty can be performed under local anaesthetic – removing the necessity of interrupting glycaemic regimens in people with diabetes.

Following lunch, John Timmons (Tissue Viability Nurse, Grampian) and Paul Chadwick (Principal Podiatrist, Salford) presented a discussion on wound debridement. John and Paul stressed that debridement is one of the key elements of good wound care because of its immediacy; debridement allows exposure of the full extent of the wound and removal of non-viable issue that may be a barrier to healing, or a harbourer of bacteria, and frequent debridement keeps the wound on course for healing (Leaper, 2002).

Paul suggested that photographs of feet pre- and post-debridement should be taken by clinicians both to measure the improvement of the wound and to have a record for possible legal action. Paul and his team currently request written consent from people in whom aggressive debridement is undertaken, and he suggested that in the future written consent will need to be taken for all debridement.

Next, Martin Fox (Vascular Podiatrist, Manchester) and Scott Cawley (Lead Specialist Podiatrist, Cardiff) provided an interactive session on heel protection. During periods of immobility, the localised pressure that occurs in the heels

Figure 1. Scott Cawley demostrates the application of a soft heel cast on a volunteer masterclass attendee.

can result in excessive pressure or friction, manifesting as pressure lesions or ulcers. One modality that has shown good results around healing and pain reduction in a case series is the pressure relief achieved through soft casting techniques. Scott demonstrated how to make a cast (*Figure 1*) and then Martin invited four volunteers from the audience to apply a cast to four other volunteer judges. In this impromptu "Strictly Come Casting", the volunteer casters were judged on the quality of the cast they produced – all received an 8–9/10 – highlighting the ease of use and potential for competency development among clinicians working in wound care teams.

Research suggests that one in seven people with diabetes have neuropathic pain (DNP), and that only one in three is treated for it (Daousi et al, 2004). In the next session, Sue Benbow (Consultant Diabetologist, Liverpool) discussed DNP and stressed that people with diabetes should be asked about foot pain at every screening. Furthermore, Sue suggested that people with diabetes be asked to describe pain over a 24-hour period, as pain can be worse at night.

In the last session of the masterclass, Professor William Jeffcoate (Consultant Endocrinologist, Nottingham) and Martin Fox discussed *Putting Feet First* (Diabetes UK, 2009), guidelines for the commissioning of specialist services for the management and prevention of diabetic foot disease in hospitals. William stressed that the challenges of implementing the guidelines are both organisational and professional, with the involvement of hospital management being key. William hoped that forthcoming implementation strategies will help healthcare professionals and commissioners agree on a pathway of care for the diabetic foot in hospitals.

Martin asked: How we can make the guideline come to life? He supplied the group with a simple spreadsheet-based, self-audit tool that could be used to reflect on the current management of acute diabetic foot disease among people admitted to the hospital in which they work. The tool is broken up into the three periods of care given in *Putting Feet First* (admission–4 hours; 4–48 hours; 48 hours–continuing specialist care), and covers the elements of investigation and intervention during each. The self-audit tool can be used to highlight service strengths and weakness in relation to the guideline and identify areas for change.

More information on the masterclass and selected tools can be accessed on the FDUK website www.footindiabetes.org ■

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