

# (I saw) the SIGN



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The Scottish Intercollegiate Guidelines Network (SIGN) is, deservedly, renowned for producing high-quality, evidence-based, practical treatment guidelines. SIGN methodology has been refined over the years and the latest diabetes guideline – 116 (SIGN, 2010) – has the most rigorous methodology yet.

Revising evidence-based guidelines for the diabetic foot when the evidence base is so limited was problematic. The SIGN Foot Disease Subgroup was asked to limit updates to new evidence since the previous version SIGN 55 (2001), centering on eight key questions. So what is new in the foot-related content of SIGN 116?

It is longer than SIGN 55, which is a step in the right direction. There are five main sections: epidemiology, preventative management, management of active foot disease, painful neuropathy and an information checklist. The epidemiology section was not one of the key questions and remains unchanged.

The foot screening section is more logical and user-friendly than previously. The checklist for the provision of information is a feature of all SIGN 116 sections and is one of the most practical parts of the whole document.

The recommendation that all people with diabetes should have access to structured diabetic foot care has been removed. I agree with this. Universal access for people with diabetes to podiatry is unsustainable and those with no established risk factors have such a low risk of ulceration (Leese et al, 2006) that podiatry is unlikely to have a measurable preventative effect.

It is unfortunate that the question of footwear was not one of the key areas for updating as the previous recommendation of “trainers for all” is derived from a 1995 reference and should have been improved for the previous version. However, post-2003 evidence would probably still

not have been strong enough for change in this important area of care.

It is in the area of managing active diabetic foot disease that the limitations of the evidence base are most clear. Little of what we do in diabetic foot clinics has more than uncontrolled studies and case series to back it up. At least the recommendation that all patients with ulcers should be referred to a multidisciplinary foot care service has been made explicit – although, most of the evidence for this is now quite old.

The importance of the pharmaceutical industry funding clinical trials is highlighted; the only major randomised controlled trials in the foot section of SIGN 116 are in the area of diabetic peripheral neuropathic pain. As a result, the statements on this section were the only grade A recommendations in the entire foot section.

A level of evidence equal to that supporting treatments for diabetic peripheral neuropathic pain is needed to answer why some at-risk people do not ulcerate. Whether, which and for how long are antibiotics needed? How can the burden of recurrent ulceration be reduced? And so on.

Despite growing recognition of the burden of diabetic foot disease, its management will remain more art than science until we can get better evidence to support what we know from our clinical experience works. Hopefully, grant-awarding authorities will see the wisdom of supporting, or even commissioning, research on the diabetic foot so that the next guidance update group can have more hard evidence to work with. ■

Leese GP, Reid F, Green V et al (2006) Stratification of foot ulcer risk in patients with diabetes: a population-based study. *Int J Clin Pract* 60: 541–5  
Scottish Intercollegiate Guidelines Network (2001) *Management of Diabetes: A National Clinical Guideline 55*. SIGN, Edinburgh  
Scottish Intercollegiate Guidelines Network (2010) *Management of Diabetes: A National Clinical Guideline 116*. SIGN, Edinburgh

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