The 2010 Foot in Diabetes UK Masterclass

The Three Cs: Complex Clinical Conundrums

Karl Guttormsen

This is a report from the *6th Annual Foot in Diabetes UK (FDUK) Masterclass on the Foot in Diabetes*, which took place on 2 December 2010 at the Lancashire County Cricket Club, Manchester.

"Neither snow nor rain nor heat nor gloom of night stays these couriers from the swift completion of their appointed rounds."

Herodotus c. 484 BC – c. 425 BC

Thus was the commitment of the organisers of this year's FDUK Masterclass, who prevailed – despite the weather – to deliver a remarkable event! The programme was an eclectic assortment of learning media ranging from case studies, debates, videos and working through complex clinical scenarios. At the 1-day event an interactive and stimulating learning environment was created by prestigious experts in the field of diabetic foot care. The topics were interesting and varied.

The group's Chair Louise Stuart MBE (Consultant Podiatrist and Lecturer, Manchester) welcomed delegates and congratulated them for braving the treacherous weather conditions. Louise then introduced a symposium organised and sponsored by BSN medical (Hull).

Debbie Rough (Vascular Specialist Nurse, Pennine) was the first of three speakers participating in the symposium and began by highlighting the pressure on clinicians to justify their dressing choice, especially with regard to the antimirobial dressing preparations. Debbie discussed some of the available agents and lamented that many kill bacteria but leave debris in the wound. She suggested that the fatty acid derivative dialkyl carbamoyl chloride component of Cutimed Sorbact® (BSN medical, Hull) as being an effective alternative that may also be used prophylactically. Next, Samantha Haycocks (Advanced Podiatrist, Salford) presented an evaluation of Cutimed Sorbact® in nine people with 17 episodes of diabetic foot ulceration. At the start of the study period, 82% of ulcers demonstrated at least two clinical signs of infection, but after a week of treatment including Cutimed Sorbact® only 18% had signs of infection. Finally, Martin Turns (Lead Podiatrist in Diabetes, Brighton) presented two case studies of hard-to-heal diabetic foot ulcers. Despite the long-standing nature of the wounds – up to 2 years' duration – with the use of Cutimed Sorbact® and good traditional wound care, both went on to heal.

Louise next introduced Martin Fox (Vascular Specialist Podiatrist,

Manchester) who spoke on addressing peripheral arterial disease in the diabetic foot. Martin reminded delegates that intermittent claudication is an indicator of underlying systemic disease; while two out of every 100 patients with peripheral arterial disease will undergo a lower-limb amputation in a 2-year period, 30 in every 100 will have fatal cardiovascular events during the same period. He challenged the audience to review their perceptions of peripheral arterial disease and described the activities of his specialist peripheral arterial disease service in north Manchester. Martin demonstrated the north Manchester specialist peripheral arterial disease team's cost-effectiveness, its value to the local vascular surgeon and the improvement in outcomes for people with this often neglected condition.

Next, Melanie Doxford (Diabetic Foot Practitioner and Principal Podiatrist, London) discussed diabetic foot care for people with renal disease. Diabetes is the leading cause of renal disease and the incidence of major amputation is 30% among people with diabetes receiving dialysis (Eggers et al, 1999). Melanie provided data from the King's College (London) vascular department which suggest that renal failure does not predict poor outcomes in terms of primary or primary assisted distal graft patency or major amputation. However, aggressive infection control is vital in achieving good outcomes in this population. She concluded that, with the various skills contributed by the multidisciplinary foot care team, the diabetic foot can be salvaged during end-stage kidney disease.

Following lunch, Dr Mike Edmonds (Consultant Physician, London) introduced Louise and Lynne Watret (Tissue Viability Nurse, Glasgow) to present opinions from two professional backgrounds on the management of heel ulceration. Louise spoke first and reminded the audience that 7% of diabetic heel ulcers result in amputation and a further 20% persist until death (Vanderwee et al, 2007). She emphasised the difficulties of treating heel ulceration, but said that a standardised approach to classification (e.g. the National Pressure Ulcer Advisory Panel's Updated Pressure Ulcer Staging System [Black et al, 2007]) may be of benefit. She concluded that heel protection pathways are essential and that care must be standardised for good outcomes to be achieved by all patients, regardless of where they are treated. Louise emphasised the importance of multidisciplinary care of the ulcerated heel, with podiatrists and nurses having a complementary mix of knowledge and skills.

Lynne challenged the audience to take responsibility for championing the management of heel ulceration, whatever their role. Ultimately, she stressed that each of the involved professional groups has a stake in heel ulcer care and that we must work together to tackle this devastating problem.

Dr Edmonds followed Louise and Lynne's presentation with a series of three interactive "clinical conundrums" – difficult case studies. The first case focused on developing delegates' appreciation of the importance of addressing infection and ischaemia in the diabetic renal foot, and their roles in limb salvage in this vulnerable group. The second case was an atypical presentation of necrotising fasciitis. Dr Edmonds noted there was no muscle breakdown in this case – established by the creatine phosphokinase level – and the limb was salvaged following surgical debridement. The third and final complex clinical conundrum highlighted the benefits of radiograph, revascularisation and offloading in the diagnosis, treatment and subsequent management of diabetic foot ulceration.

Dr Edmonds went on to introduce a lively debate: "This house believes that the widespread use of advanced wound products and dressings in the management of diabetic foot ulceration is justified". Professor Richard White (Professor of Tissue Viability, Worcester) was for the motion and Professor William Jeffcoate (Consultant Endocrinologist, Nottingham) against.

The audience was 94% in favour of the motion at the outset. The speakers then very articulately argued their cases with conviction. Professor Jeffcoate was undeterred by having to present via telephone and managed to turned the audience's opinion to a 70/30% split against the motion. Professor Jeffcoate concluded that, in the absence of clinical evidence on efficacy, the most cost-effective treatment should be offered.

Louise informed the delegates that, to better include colleagues in tissue viability, the FDUK Masterclass would be held alongside the Wounds UK Conference in Harrogate in 2011. This brought a close to a thoroughly interesting and informative day. ■

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Eggers PW, Gohdes D, Pugh J (1999) Nontraumatic lower extremity amputations in the Medicare end-stage renal disease population. *Kidney Int* **56**: 1524–33

Vanderwee K, Clark M, Dealey C et al (2007) Pressure ulcer prevalence in Europe: a pilot study. *J Eval Clin Pract* **13**: 227–35