Diabetic foot guidelines and beyond

This is a report from the *12th Annual Conference of The Diabetic Foot Journal*, 6 June 2011, Our Dynamic Earth, Edinburgh.

This year's conference examined the Scottish SIGN guidelines for the diabetic foot – but, rather than simply considering what the guidelines recommend, the speakers question their achievability, and even desirability, in practice.

Co-chairs of this year's conference, Dr Matthew Young (Consultant Physician, Edinburgh) and Professor Graham Leese (Chair, Scottish Diabetes Group), welcomed the delegates and asked them to use the interactive keypads to identify the split of professions. It was discovered that the delegates comprised 85% podiatrists, 6% orthotists, 5% doctors, 2% nurses and 2% other, with 90% practicing in Scotland.

Professor Leese reminded the delegates that it is only recently that evidence-based medicine has become the order of the day – but that a lack of evidence does not mean that a treatment is ineffective. It may be variously unethical to conduct a randomised controlled trial (e.g. cardiopulmonary resuscitation) or the money to conduct trials may be limited to those areas with industry funded research opportunities (e.g. expensive drug types). Professor Leese highlighted that evidence-based guidance is not "always" the answer, and why it is important to interrogate such guidance in order to achieve the best care for people with diabetes.

Dr Brian Kennon (Consultant Diabetologist, Glasgow) looked at the importance of screening and risk stratifying the diabetic foot, and the role that the primary care team can play in this process. He reminded the delegates that screening and risk stratification have been shown to have good predictive value (Leese et al, 2006; 2011), but only when the information gained in this process is used to prevent future ulceration in the high-risk group are we really doing the person with diabetes a service. However, a question remains as to who is going to conduct risk stratifications, with 14% of the delegates voting that screening was the role of podiatrists, 19% saying that primary care should screen and 67% saying "everyone".

Next, Jane McAdams (Chief Podiatrist, Salford) discussed whether – as per the SIGN recommendations – running shoes are practical for all people with diabetic foot disease. Jane described the poor evidence for any footwear advice for people with diabetes, with a 2000 Cochrane review finding there to be no strong evidence for the ability of running shoes to prevent foot ulcers in people with diabetes. Yet, advice on footwear is essential to preventing ulceration and must be given, and Jane suggested clinicians focus on small positive changes in footwear choice.

After a break for coffee and viewing of the exhibition hall, Joanne McCardle (Advanced Acute Diabetes Podiatrist, Edinburgh) opened the second session with a discussion of what the multidisciplinary team (MDT) can offer people with diabetic foot disease. Although not level A evidence, referral to an MDT has been shown to have a positive effect on outcomes (Edmonds et al, 1986). Joanne used the keypads to determine that, although 75% of the audience had access to an MDT, 19% did not and 6% were unaware of whether their region had one or not. The MDT will move from a clinic to a "service" over time, providing the right care at the right time from the right healthcare professional, and will make use of e- and tele-health technologies.

Dr Matthew Young spoke on how the MDT deals with not just the foot – because foot disease is a marker for a range of other conditions (Boyko et al, 1996) in very complex patients. The various members of the team will participate variously in this care, and keypad voting revealed that 64% of delegates felt that they could manage neuropathic pain medications, given the right training as part of the Patient Treatment Group Directive. The skills and outcomes of the MDT, Dr Young stressed, need to be shown in ongoing research and audit conducted by the team, and graduate and non-specalist colleague placement with the MDT should be encouraged.

William Munro (Orthotic Director, Clydebank) described the fundamental building blocks of offloading, pressure, friction and shear in a presentation on offloading in practice. William found that a lot of terminology clouds communication, and that there is a need for all members of the MDT to better understand the range of offloading devices available, and strong and ongoing links – not one-off jobs – need to be forged with plaster rooms.

The next speaker, Paul Chadwick (Principal Podiatrist, Salford) looked at why SIGN and NICE both make so few recommendations for wound care, and what might be done without them. Paul highlighted the pieces of evidence that we have on the effectiveness of dressings, and reminded delegates that both sets of guidance leave a lot of scope for clinician choice. As dressing form one part of the wound healing jigsaw, Paul suggested exercising a critical eye and undertaking dressings-related research as part of our practice.

Dr Andrew Seaton (Consultant in Infectious Disease and General Medicine, Glasgow) spoke next on the lack of recommendation on antibiotics in national guidelines, and what to do in their absence. NICE recommends that each hospital or trust should have its own antibiotic guidance, and the treatment of diabetic foot infection should fit within this wider policy. Dr Seaton stressed that infection control is a moving target and temporal changes in infecting agents and their resistances to antibiotics requires careful antimicrobial stewardship.

Next came a lively debate, titled this House believes distal bypass had bypassed the person with diabetes. Professor Peter Stonebridge (Consultant Vascular Surgeon, Dundee) took the affirmative position and held that while intervention by a vascular surgeon can salvage ischaemic diabetic feet that would otherwise undergo amputation, this result is far from guaranteed. Professor Cliff Shearman (Consultant Vascular Surgeon, Southampton) took the negative position, saying that if we really want to make a difference in amputation rates, revascularisation is the key and failures in achieving reductions (Moxey et al, 2010) are unacceptable and contra to national guidance.

The final session was opened by Dr Young, who discussed why inpatient diabetic foot care is not only a hospital issue. He held that the referral pathway for the diabetic foot needs to start in the emergency department and include the appropriate onward referral through to appropriate follow-up in the community setting.

Dr John McKnight (Consultant Physician, Edinburgh) spoke next on the work of the Scottish Diabetes Group. He said that Managed Clinical Networks will be the key to delivery of the *Diabetes Action Plan 2010* (Scottish Government, 2010), and that the Scottish diabetes care systems are driving new data that allows for the provision of better care for people with diabetes. Dr McKnight was joined by Duncan Stang (National Diabetes Foot Coordinator, Scotland), who highlighted the work of the Foot Action Group and launched the FRAME website (a full report on this can be found on page 116 of this issue of *The Diabetic Foot Journal*). ■

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