Diabetic Foot Guidelines and Beyond

A report from the *12th Annual National Conference of the Diabetic Foot*, held on 20 October 2011, Hotel Ibis, Earls Court, London.

Management of the diabetic foot takes place in a near vacuum of clinical evidence; in its absence, we rely on common sense, experience and practical guidance. But what are the implications of this approach for the healthcare professional, the health service and the person with diabetes? This year's conference examined national and international guidelines on the management of the diabetic foot in community and hospital settings, and question their implications in practice.

The conference was Chaired jointly by *The Diabetic Foot Journal's* Editors-in-Chief, Dr Matthew Young (Consultant Physician, Edinburgh) and Alistair McInnes (Senior Lecturer, Brighton) who welcomed the delegates to the conference and invited them to actively participate in the day's sessions.

The first session of the day was titled "Guidelines in Practice: Prevention Management". The first speaker was Paul Chadwick (Principal Podiatrist, Salford), who addressed the way in which primary care teams can help to prevent diabetic foot ulceration. Paul stressed that foot screening, that generates an ulcer risk stratification, which determines appropriate management by healthcare professionals with the right mix of competencies, sits at the heart of ulcer prevention.

Next, Jane McAdams (Principal Podiatrist, Salford) presented on footwear and orthotics in diabetic foot ulcer prevention. Jane looked at the contradictory information and guidance that exists, for both healthcare professionals and patients, on footwear choice. A number of questions remain on the best choices of footwear for people with diabetes, and Jane suggested that more research is needed in this field.

In the second session of the day, Professor William Jeffcoate (Consultant Endocrinologist, Nottingham) addressed the care of the inpatient diabetic foot. Professor Jeffcoate discussed that a deluge of guidelines had been released in the last 12 months on this topic. Professor Jeffcoate stressed that, although the range of guidance may feel overwhelming, they do all contribute to marring-up care from community to hospital bed, and it is up to us to ensure that services reflect this.

In the next session Lynne Watret (Tissue Viability Nurse, Glasgow) and Dr Chinari Subudhi (Consultant Microbiologist, Salford) delivered practical advice on what to do in the absence of evidence. First, Lynne examined the question of dressing choice for diabetic foot ulceration. She said that dressing selection is important and can affect the outcome of ulceration, but that dressings alone are insufficient to heal these wounds unless combined with best practice in the management of the diabetic foot. Lynne suggested that delegates consider the SIMPLE acronym when choosing a dressing: Safety, Indicated, Measurable, Patient advantage, Longevity, End point. Dr Subudhi discussed infection in the diabetic foot, and stressed that it should be considered as a medical emergency. While compliance with empiric antibiotic guidelines is needed in initial management of infections, Dr Subudhi gave examples of how regimens can be subsequently modified depending on clinical response, microbiological results and radiological evidence, and that microbiological expertise is an integral part in the management of diabetic foot infections.

After lunch, Dr Young chaired a debate: This House believes that amputation should be a good therapeutic option for the diabetic lower limb, not a last resort. The debaters were Dr Ernest Van Ross (Director, Pace Rehabilitation), taking the for position, and Dr Mike Edmonds (Consultant Physician, London) taking the contra position. Dr Van Ross lamented the too common scenario of a "defeated" healthcare professional discussing amputation with an ill, despondent person with diabetic foot ulceration and the amputation proceeding in haste at the most inopportune time for the person, reducing the

Professor William Jeffcoate discussing inpatient care of the diabetic foot.

Professor Mike Edmonds arguing that amputation of the ulcerated diabetic foot should only be a last resort.

chance of stump wound healing. He held that is does not have to be this way; he gave examples of how a timely amputation ablates a diseased part and offers an informed and prepared person a fresh chance to regain mobility.

Dr Edmonds disagreed, and said that advances in the past three decades have established limb salvage as an effective mode of treatment for diabetic foot disease. For the ischaemic foot, he reminded the delegates, it is a rare occurrence now to find a person who cannot be helped by angioplasty. Limb salvage should be tried in the first instance in the management of the diabetic foot, Dr Edmonds concluded, with major amputation reserved as a final resort.

Dr Stephen M Thomas (Consultant in Diabetes and, Endocrinology, London) considered the question of what GP commissioning will mean for the diabetic foot. Dr Thomas stressed that we must find a way forward in the new system, as – like it or not – we are now pass the point of no return. He suggested that a number of documents and examples of best practice from around the UK exist to demonstrate the set-up of a good diabetic foot service and these can be followed locally.

Next, Louise Stuart MBE (Consultant Podiatrist, Manchester) described the result of a survey on the diabetes specialist podiatrists in England. Louise stressed that there is no definitive definition or competency set that is common to those podiatrists who work with the diabetes foot, and of the 512 respondents to the survey, they reported 233 different job titles. She said that podiatrists who work with the diabetic foot, commissioners and workforce planners should take these results as a wake-up call; a critical look must be taken at how diabetic foot specific competencies are gained and proven in the UK.

Finally, Joanne McCardle (Advance Acute Diabetes Podiatrist, Edinburgh) spoke on the future of diabetic foot care in a changing environment. Joanne held that we must recognise that specific skill sets are required to manage the diabetic foot at different stages, from screening through to the treatment of active foot disease. The Diabetes Foot Competency Framework is a multidimensional, clinical, competency-based framework that outlines these competencies, and the first phase of the Framework's development has been completed and 2012 will see the release of a user guide to aid podiatrists, and others, to plan, gain and prove competency to care for the diabetic foot. ■

Clinical Editor-In-Chief of *The Diabetic Foot Journal* awarded an Honorary Fellowship of the Faculty of Podiatric Medicine

On 21 September 2011, Dr Matthew Young (Clinical Editor-In-Chief of *The Diabetic Foot Journal* and Consultant Physician, Royal Infirmary of Edinburgh) was awarded an Honorary Fellowship of the Faculty of Podiatric Medicine. The Fellowship was given in recognition of Dr Young's work in diabetic foot care and his ongoing support of the podiatry profession.

The ceremony was held at House of Lords in London. The presentation was made by Lord Morris, Patron of the Society of Chiropodists and Podiatrists and Professor Stuart Baird, Chair of Society of Chiropodists and Podiatrists.

The Society of Chiropodists and Podiatrists is the professional body for registered podiatrists. The Society came into being in 1945 when five British chiropody organisations amalgamated. The Society now represents around 10 000 private practitioners, NHS podiatrists and students. ■

Dr Matthew Young with his Honorary Fellowship of the Faculty of Podiatric Medicine, awarded for work in diabetic foot care and his ongoing support of the podiatry profession.