Sock it to me: Diabetic foot care in the community

Brian Karet

Diabetes UK (2006) *State of the Nations 2006*. Diabetes UK, London

DoH (2006) *Turning the corner: improving diabetes care*. DoH, London

Melville A Richardson R, McIntosh A et al (2000) *Quality in Health Care* **9**: 137–41

Missouris CG, Kalaitzidis RG, Kerry SM et al (2004) *British Journal of Diabetes and Vascular Disease* **4**: 196–200

Morris AD McAlpine R, Steinke D et al (1998) *Diabetes Care* **21**: 738–43

NICE (2005) *Commissioning a foot care service for people with diabetes*. NICE, London

Ragnarson Tennvall G, Apelqvist J (2000) *Journal of Diabetes and its Complications* **14**: 235–41

Ramsey SD, Sandhu N, Newton K et al (1999) *Diabetes Care*, **22**: 382–7

Walters DA, Gatling W, Mullee MA et al (1992) *Diabetic Medicine* **9**: 354–8

Young MJ, Boulton AJM, MacLeod AF et al (1993) *Diabetologia* **36**: 150–4

Brian Karet is a GP at Leylands Medical Centre, Bradford and a GPSI in Diabetes.

All of us delivering diabetes care already know by now that diabetes is increasingly common: it currently affects approximately 2.3 million people in the UK (Diabetes UK, 2006). It is also an expensive condition, taking up an estimated 10% of NHS and 5% of social costs (DoH, 2006). We also know it is the commonest cause of non-traumatic lower limb amputations – one of the reasons we spend so much time in clinics optimising care and detecting complications.

But how well do we understand the impact of foot disease and how organised are we in assessing and treating it? At any one time about a quarter of our patients have diabetic neuropathy and around 2% will have a foot ulcer (Young et al, 1993; Ramsey et al, 1999). Additionally, the costs incurred by foot ulcers escalate by five hundred percent in the first year after diagnosis.

A person with diabetes is 13 times more likely to have a lower limb amputation than someone who does not (Morris et al, 1998). It is hardly surprising that quality of life is reduced after an amputation, but people with current foot ulcers also rate their quality of life significantly lower than those whose ulcers have healed (Ragnarson Tennvall and Apelqvist, 2000). Peripheral vascular disease is implicated in more than half of all diabetic foot problems (Walters et al, 1992) and in a recent study over half the participants with symptomatic peripheral vascular disease died within 5 years – people with diabetes faring particularly badly (Missouris et al, 2004).

So there is plenty of bad news but there is also some evidence that structured multidisciplinary care combined with patient education does improve outcomes for people with foot problems (Melville et al, 2000). So what should a community based diabetes foot care service look like? The components spelled out by NICE (2005) are described in *Box 1*.

As long as all these components are in place, the placement and organisation of services can be left to local diabetes planners. However, there are some factors that are crucial to success. For example, it is almost impossible to have regular reviews without effective call and recall systems, which in turn require integrated computer systems – without which comprehensive audit cannot be undertaken.

The training and educating of healthcare professionals is crucial and everyone involved in delivering diabetes care should know how to do a basic foot examination involving three core activities:

- inspection
- monofilament sensation testing
- palpation of pulses.

Early recognition and treatment of foot problems is important to avoid chronic problems. These early indicators include superficial fungal infection best treated with terbinafine cream.

We need to use the podiatry, vascular and wound care expertise in out multidisciplinary teams and establish clear pathways in order to make sure all people with diabetes get regular foot care and that everyone has the skills to refer appropriately those people more at risk. In the following article, Neil Baker and Duncan Fowler comprehensively describe how to examine the diabetic foot – so no one should be wary of saying 'come on then, get your socks off!' ■

Box 1. Components of an effective foot service.

- Regular review
- Risk factor assessment and reduction
- Risk factor education
- Foot risk stratification
- Direct access to at-risk foot clinics
- Specialist skin and nail care
- Specialist footwear advice
- Specialist wound care and ulcer treatment