Seamless diabetic foot care

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Living with a diabetic foot ulcer is a miserable experience. The daily activities of the individual and his or her family inevitably revolve around the ulcer: it can affect employment and, therefore, earning capacity, social life, relationships and quality of life. It is no wonder that people with diabetic foot complications are more at risk of depression (Boulton et al, 2004). Even with the benefits of the expertise of the diabetic foot clinic it may take months for an ulcer to heal, with the dread of possible amputation at the fore of the person's mind.

The development of a diabetic foot ulcer illustrates a key concept about diabetes care: good quality, routine and simple care, including self-management skills, can prevent the condition from becoming more complex.

The hospital diabetic foot clinic service, such as that described by Jane McAleese (see page 346), is an excellent example of multidisciplinary team working. The close liaison between a variety of different healthcare professionals provides a holistic, patient-centred service, focused on facilitating the resolution of an individual's diabetic foot complications. The team may include a consultant diabetologist, DSN, dietitian, pharmacist, orthotist and podiatrists, and have fast access to tissue viability services, and vascular surgeons. The healing of a foot ulcer involves more than just the foot: a healthy eating plan can promote healing, conversion to insulin may be required to improve glycaemic control, identification of an effective antibiotic may avoid a long stay in hospital.

The management of risk factors, supporting a healthy lifestyle, regular review and patient education are, in my view, essential in preventing the development of foot complications. The existence of a comprehensive multidisciplinary diabetic foot team for diabetic foot complications is a wonderful service but wouldn't it be better if the service was not required?

Nazma Toofany (see page 341) describes the service provided to people with diabetes attending the practice she works at. The impact of the General Medical Services contract and the pursuit of attaining targets in numerous quality indicators is improving the provision of primary care diabetes services in many areas. The inclusion in the Quality and Outcome Framework of screening for vascular and neuropathic foot complications means that these conditions can be identified at an earlier stage. Patient education, either through community-based group sessions after initial diagnosis or through the ongoing education given during the annual review by the practice nurse, informs individuals of the potential risk of problems in their feet and importantly what they can do to avoid them. Another target is improving risk factors for complications: blood pressure, lipids, HbA_{1c}, weight and smoking.

Some people can be at particular risk; Nazma describes the special provisions made for the large South Asian population her practice serves. For example, being aware of the difficulties in attending the Islamic pilgrimage of Hajj allows her to appropriately advise her patients who intend to undertake it. The investment by the practice in a podiatrist who speaks a language spoken by some hard-to-reach individuals may ultimately save costs in the future by increasing understanding of self-care of the diabetic foot.

The link between the preventative and educating services delivered in the primary setting services and the comprehensive service provided for the person with diabetic foot complications in the diabetic foot clinic has got to be the existence of clear guidelines and referral pathways. The classification of each individual into potential risk categories means those at high risk are seen quickly so that damage, such as amputation, can be minimised or averted. If foot management is provided by the appropriate person at the right time and in the right place it helps to ensure that the relatively scarce resources of the specialist podiatry team are focused on providing care for complex foot problems. The stratification of care provision according to need is cost-effective – an important concept in the cash-strapped NHS of today. However, the most important person in the prevention and management of diabetic foot problems must be the informed patient. ■

Boulton AJ, Kirsner RS, Vileikyte L (2004) Clinical practice. Neuropathic diabetic foot ulcers. *New England Journal of Medicine* **351**(1): 48–55

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