

SCREENING AND MANAGEMENT OF FOOT COMPLICATIONS

THE DIABETIC FOOT

Aims of Diabetic Footcare Advice

- Education of patients and/or carers on the importance of self-care
- Prevention of trauma and subsequent development of foot lesions
- To aid healing of established lesions and prevention of recurrence
- To maintain patient mobility and avoid hospital admission
- Adherence to national guidelines, to reduce the morbidity associated with diabetic foot disease

Objectives of Diabetic Footcare

- To provide all diabetic patients with education on foot care
- To ensure that all patients receive annual foot examination
- To provide a service whereby patients are referred appropriately to members of a specialist team, according to level of risk

State Registered Podiatrists play an important role in the education, monitoring and treatment of patients presenting with lower limb complications of the diabetes. Podiatrists do not routinely need to see low risk patients unless they have a foot pathology.

General Principles

- All diabetic patients should receive education in foot care, to reduce the incidence of chronic ulceration, gangrene and amputation.
- Foot examination should be performed at the annual review visit in all patients ([see p22](#))
- Use of a 10g Monofilament is recommended.
- Ongoing management depends upon **risk stratification** ([see p50](#)). For summary, [see Appendix 2](#)

Testing Pressure Sensation with a Monofilament

- **Monofilaments are designed to deliver a standard stimulus usually 10g force**
- **Test a total of 10 sites: 1st, 2nd 3rd & 5th plantar metatarsal heads and plantar aspect of great toe, in both feet**
- **If the patient is able to feel \leq 8/10 touches with a monofilament, then the risk of foot ulceration is increased 5-10 fold.**

RISK STRATIFICATION FOR DIABETIC FOOT DISEASE

1. Low Risk Patients

- No clinical signs of peripheral vascular disease or neuropathy
- Display none of the features listed below

Provide with leaflets & education

Refer to podiatry only for podiatric problems

2. Moderate Risk Patients

- Clinical evidence of neuropathy [10g monofilament]
- Absence of foot pulses
- Presence of foot deformity
- Visual impairment
- Physical disability

Provide with leaflets & education

Refer for regular podiatry

3. High Risk Patients

- Clinical evidence of neuropathy [10g monofilament] with callus
- Presence of foot deformity with callus
- Present or previous history of ulceration
- Peripheral vascular disease - absent pedal pulses with history of intermittent Claudication or rest pain or in combination with neuropathy
- Previous amputation
- Previous Charcot Neuroarthropathy

Provide with leaflets & education

Refer to specialist diabetes podiatry service

[Foot Clinic, Diabetes Clinic, Community Podiatry]

All ulcers should be referred

FOR PATIENTS WITH ANY OF THE FOLLOWING

- **Foot ulceration**
- **Active Charcot Neuroarthropathy**

**Arrange for URGENT REVIEW by a Specialist Podiatrist
who is a member of a Hospital Diabetes Team**

- **Diabetes Specialist Foot Clinic, Royal Infirmary of Edinburgh, 5 days a week**
 - **St John's Hospital, Livingston, Wednesday, Thursday, Friday**
 - **Roodlands Hospital, Tuesday, Thursday**
 - **Western General Hospital, 5 days a week**
 - **Eastern General Hospital, Friday morning**
- [\(hyperlink\) Contact details](#)**

Basic Footcare Advice for Patients

Do	Do Not
Examine feet daily, including between toes and around heels	Wear ill-fitting shoes
Check footwear for small objects or rough seams	Burst blisters
Wash feet daily and dry thoroughly	Sit too near heaters or fires or use hot water bottles to heat feet up quickly
Check water temperature with elbow before bathing feet	Poke down edges of nails with scissors to cure ingrown toenails
Switch off electric blankets and remove hot water bottles before going to bed.	Use razor blades, pumice stones or corn remedies
Ask for feet to be measured when buying shoes	Wear sandals if there is any loss of sensation in the feet
Follow this advice and have feet checked regularly	Go barefoot.

MANAGEMENT of DIABETIC FOOT COMPLICATIONS

1. General Measures

Education

- Outline the do's and don'ts of footcare
- Provide with advice leaflets about footcare and suitable footwear

Regular Podiatry

- General footcare and routine podiatry treatments
- Debridement of ulcers
- Continuing education.

Orthotics

For patients with established neuropathy, pressure relief is a mainstay in the prevention and treatment of ulceration. This may be achieved using:

- Seamless shoes or insoles
- Plaster casts or Scotch casts

2. Ulceration: Simple Dressings

A wide range of dressings, with different indications for use is available

- **Alginates** (e.g. Kaltostat, Sorbsan): Suitable for moist exuding wounds
- **Hydrogels** (e.g. Intrasite): Tend to keep wound moist, but may help to absorb a little exudate
- **Hydrocolloids** (e.g. Granuflex, Aquacel, Combiderm): Absorbent dressings which are NOT suitable for infected wounds or very exudative ulcers. They are therefore **probably not very useful in the treatment of diabetic foot ulceration**. If they are used, then they should be changed at least every 3 days.
- **Foam Dressings** (e.g. Allevyn, Lyofoam): Suitable for use as a covering dressing and to absorb exudate.

3. Treatment of Ulceration

- **Grade 1A-2B ulcers on the Texas classification chart ([create hyperlink](#))**
- Long term antibiotic (at least 3 weeks treatment) may improve healing even in the