

Diabetic Foot Ulcers

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The Diabetic Foot Ulcer stream contained sessions on different aspects of manifestations of diabetes on the feet from the North American and European perspectives. The diabetic stream highlighted areas such as the extent of the problem, chronic wounds in diabetes, wound and risk assessments, peripheral arterial disease and infection. The presenters focused on key areas of treatment of foot ulcers, such as infection, pressure distribution and surgical intervention. The program also discussed amputation prevention strategies.

There were oral posters presented from Australia, North America, Europe, the Middle East and Japan.

This article provides highlights of some of the key areas discussed:

- Assessment and classification
- Infection
- Pressure
- Offloading
- Foot surgeries
- Amputation
- Prevention

Assessment and Classification

The area of assessment reinforced previous knowledge of the diabetic foot and reinforced the importance of foot examination and vascular and neuropathy testing.

David Armstrong pointed to a common-sense approach in assessing the diabetic foot for increased risk of tissue breakdown. This included:

- Loss of protective sensation (LOPS)
- Rigid deformity
- Previous ulcer or amputation

It was suggested that all people over the age of 40 living with diabetes should be screened for arterial disease with an ankle brachial pressure index (ABPI) and undergo noninvasive vascular tests.

Questions in the initial sessions arose regarding the number of test sites required for the monofilament test. Should it be three, four or 10? Perhaps the question should be “which scale makes the most sense to our target audience?”

There are currently several different classification systems used for the diabetic foot:

- Wagner
- Wagner Meggitt
- University of Texas
- SINBAD (**S**ite, **I**schemia, **N**europathy, **B**acterial infection, **A**rea, and **D**epth)

Some of these systems have been validated. Of the first three, the University of Texas is the most predictive. Recent work done on the SINBAD system indicates favorable results relating to its accuracy in predicting ulcer outcome. Regrettably, use of the most predictive tool has not translated into practice. In a questionnaire presented to the delegates in several sessions, the majority of people indicated that they use the Wagner system. The challenge is to always to find a system with sufficient simplicity that is also meaningful.

Infection

In the area of infection, strong controversy arose on the accuracy of probing to bone as an indicator for osteomyelitis. In conclusion, it was felt that probing to bone and NERDS and STONEES were good bedside approaches. Most experts agreed that to confirm a diagnosis of infection, further diagnostic tests were required.

Many of the speakers pointed out that when neuropathy is present, infection can progress rapidly. “Use your eyes and nose” to help guide your treatment decisions. Quick action is required for the effective treatment of diabetic foot infections.

Pressure

Foot pressure is not the only important risk factor to consider; we must also consider neuropathy (permissive factor for ulceration), deformity, history of previous ulceration.

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