Wound Sleuth

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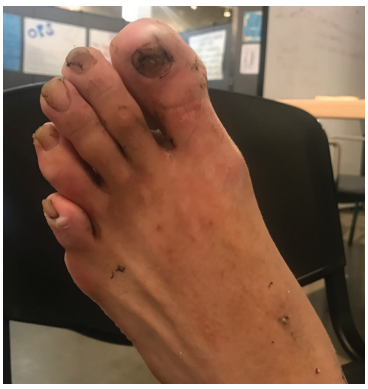
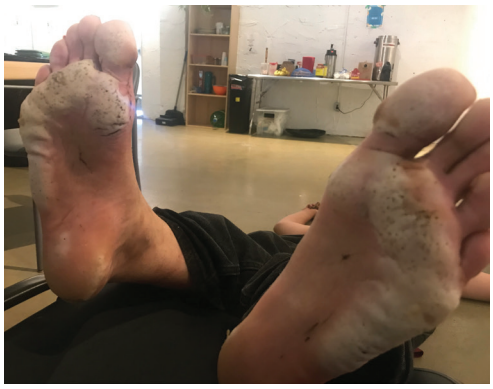
Optimizing Foot Health in a Homeless Individual

Presentation

D is a 33-year-old Indigenous man who arrives at the Moss Park Overdose Prevention Site (OPS) reporting feeling unwell. He states that he feels his blood sugar is low, and he's experiencing tingling, shooting pain to both feet. He quickly drinks some juice and then lies on the ground, elevating his feet on a chair to relieve the pain. He is agreeable to showing me his feet, which on inspection are macerated, and there is blistering to the plantar and calcaneal aspects bilaterally (see Figure 1). Otherwise, the skin is generally intact.

D reports that he is currently homeless (having arrived in Toronto from Thunder Bay a month and a half previously) and that he walks for several hours a day and sleeps outdoors with his boots on. He reports that he often doesn't take off his boots for several days at a time (as he is almost always outside). His boots became wet during a recent rainstorm and have not fully dried. D reports that he has diabetes. He knows that a normal blood sugar reading is between 4 and 7. He reports frequent episodes of low blood sugar, but is not sure if he has episodes of high blood sugar (he does not have a glucometer), and he is unsure if he has had a recent HgbA1c. Since moving to Toronto, D has not had contact with primary care; however, he does have a methadone prescriber, and when feeling unwell, he has sought help at the emergency department.



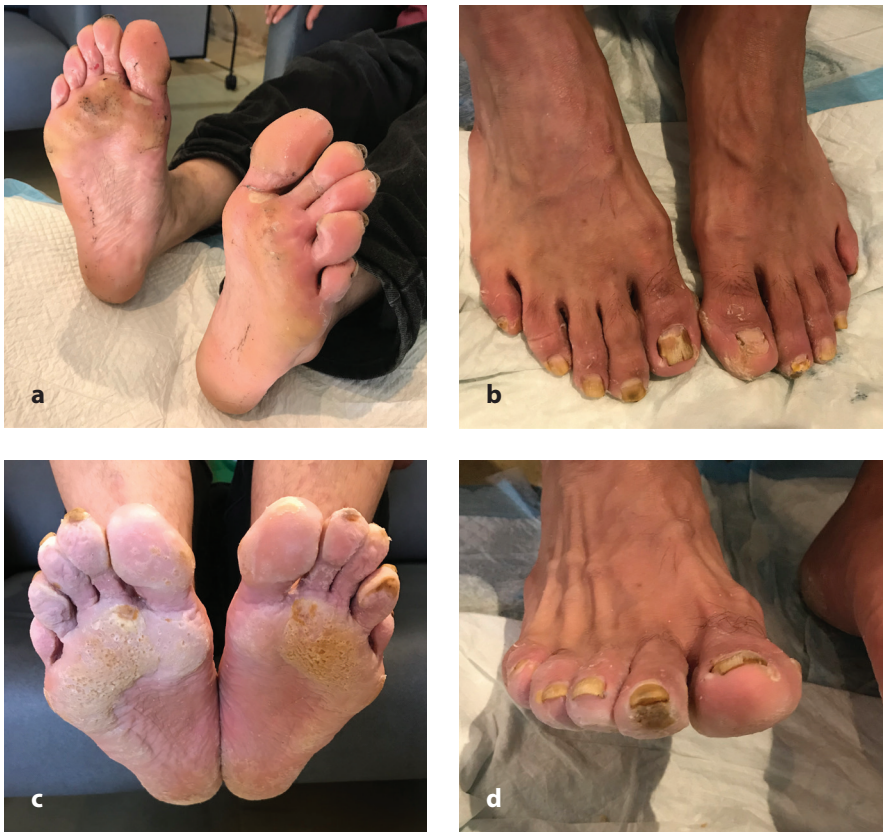


Figures 1a and b: Initial presentation

Q What are considerations for managing D's feet?

A D requires regular monitoring of his feet and skin. This is especially true if his blood sugars have been labile. At the Moss Park OPS, a service

where people can inject pre-obtained drugs with monitoring and harm reduction support, we have been able to provide him with footbaths, clean socks, and regular application of povidone-iodine when his feet become macerated. As we provide a safe space for people who use drugs, he is also able to take advantage of our full hours of operation to offload his feet and give his shoes time to dry. Povidone-iodine was chosen for the management of D's feet, as it helps to dry his macerated skin and provides broad-spectrum antiseptic action. Povidone-iodine is also an economical choice, ideal from a resource-management perspective, because OPS funding remains limited and precarious.



Figures 2a, b, c and d: Taken approximately one month after initial visit and with intermittent visits for monitoring and and management at Moss Park OPS; ongoing issues with maceration because patient remains unhoused, plus wet late summer weather

Q What kind of care coordination is required to optimize D's diabetes management?

A Required along with regular monitoring and care of his feet are capillary blood glucose monitoring and ongoing education about management of diabetes. At the Moss Park OPS we are able to provide regular capillary blood glucose checks and glucagon and snacks in the event of low blood sugar events. To manage high blood sugar readings, D would have to seek intervention at an emergency department. Ideally, he would have a primary care provider to manage monitoring and prescriptions for anti-hyperglycemics. The Moss Park OPS is able to make referrals to primary care (often via nurse practitioner clinics at South Riverdale Community Health Centre [CHC] and Street Health); however, accessing services outside of the Moss Park OPS can be a barrier to D, who on a daily basis already juggles the priorities of shelter, food, and drug acquisition for his opioid dependence, as well as pain management, which is not optimally addressed by his methadone prescription.

D would also benefit greatly from referral to a chiropodist and optimization of his footwear. As this service is not available on-site at the Moss Park OPS, there are significant barriers to D accessing DCh care. We continue to work towards finding a time when D is available and when the DCh and nurse practitioner drop-in services are running at South Riverdale CHC.

Ultimately, the health of D's feet rests on optimizing social determinants of health. D has often slept outside during the summer months. Sleeping outside leaves people vulnerable to theft of belongings. For this reason, D may be reticent to sleep without his shoes on, even if they are wet. Housing and income security would help D to co-ordinate his diabetic and skin

self-management, and other primary health care.

The Outcome

Following our initial interaction, D returned to the Moss Park OPS for three days for foot washing, application of povidone-iodine, fresh socks, and an opportunity to offload his feet and allow his shoes time to dry. This resulted in remarkable improvement to his skin: his feet were noticeably less macerated, and he reported a decrease in foot pain. D subsequently returned to the Moss Park OPS at least a couple of days a week for ongoing care and monitoring, as well to access the supervised consumption service. As D became more familiar and comfortable with the service, during one of his visits he allowed me to check his CBG (capillary blood glucose) level—it was 6.3.

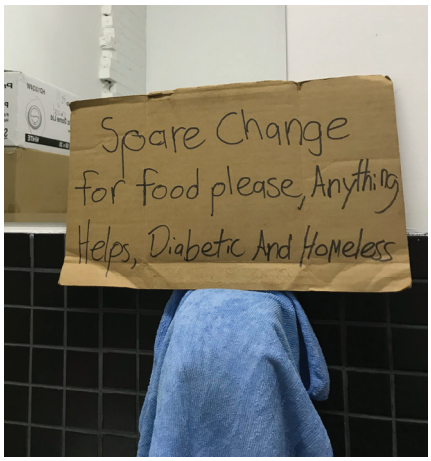


Figure 3: A sign the patient made to use when panhandling

We continue to work on connections to primary care and chiropody. As the weather gets colder, finding housing will become a priority to provide D and his feet with relief from the weather.

D was excited at the prospect of having the story of his treatment shared with others. He is passionate, as am I, about improving access to compassionate and client-centred health care for people who use drugs and people who are homeless or experiencing poverty. We both believe strongly in treating the cause—which in the case of someone like D means not only managing blood sugar, but also making changes to improve the services available to people who use drugs and addressing the systemic barriers that lead to ongoing poverty and marginalization.

1. Armstrong DG, Lavery LA, Kimbriel HR, et al. Activity patterns of patients with diabetic foot ulceration. Diabetes Care 2003;26:2595-7