Mölnlycke Sponsored Learning:

Fighting the Odds: Challenges in Diabetic Foot Ulcer Management and the Impact of COVID-19

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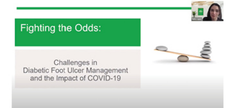

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The Impact of DFUs

Sixty percent of people with a diabetic foot ulcer (DFU) have their ulcer recur within three years. Because of this, ulcers should be thought of as being in remission rather than being closed or healed[1]. Eighty five percent of amputations related to diabetes are preceded by a neuropathic foot ulcer[2]. Approximately 20% of moderate to severe diabetic foot infections lead to some level of amputation. About 27% of people with diabetes and a lower limb amputation will not be alive in one year [3,4]. Of those who survive, about 63% will not be alive five years post amputation[5]. This five-year survival rate is worse than that of many common types of cancer[6].

The Costs of DFUs

The direct cost of treating diabetic foot complications exceeds the treatment costs for many common cancers[6]. Additionally, the cost associated with hospital admissions related to diabetic foot ulcers is more than double that associated with admissions for non-diabetic foot ulcers[7].

The Impact of COVID-19

Delayed wound care can lead to serious infections, increased hospitalizations and higher rates of amputation. Preliminary data have shown a marked increase in the rate of untreated diabetic wounds and wound-related amputations since the COVID-19 pandemic began[8]. According to a 2020 study, patients admitted with a DFU had more than three times the risk of amputation compared to those admitted in 2019[9]. Some of this impact can be attributed to the use of alternative modes of patient consultation during the pandemic when in-person appointments had to be cancelled and telephone or video-chat consulta-

Threats to DFU Management During COVID-19

- Routine lab tests, including those used for monitoring diabetes, were put on hold
- Routine investigations such as X-rays, MRIs and peripheral arterial disease screening were put on hold
- Routine non-invasive procedures such as interventional radiology were put on hold
- Non-emergency surgical procedures such as vascular bypasses were put on hold
- Non-emergency minor surgical procedures, including those for hammer toes, bony remodeling and debridement, were put on hold
- Staff specialized in managing this patient population were redeployed to acute care
- Businesses closed, reducing access to specialty devices such as footwear, orthotics and dressing supplies
- Access to foot care services, including nail and callus care, became limited or non-existent
- Home nursing services were restricted
- Some patients avoided hospitals or clinics even in severe situations due to the fear of exposure to COVID-19

tions became the predominant method of communication[10].

While managing patients with diabetes and DFUs during the pandemic, clinicians had to adapt to changing circumstances. Some strategies used to provide care included choosing dressings that were easy for the patient or care partner to apply, ensuring the patient had a supply of dressings, reinforcing the importance of callus management, reinforcing the importance of offloading, emphasizing when the patient should seek more urgent assessment and planning regular telephone monitoring. In some cases, patients were moved to a wound maintenance strategy to prevent the wound from worsening. In these cases, education, support and engagement in goal setting were critical.

Molnlycke offers a number of versatile dressings designed to optimize the management of DFUs. The Mepilex® Border Flex dressing is built with innovative flex technology that allows it to move in every direction. The dressing has five layers that absorb, channel and tap exudate and allow you to track wound progress. The dressing's Safetac technology reduces pain and trauma to the skin during dressing changes.

The Pandemic Within the Pandemic

As we begin to return to our "new normal," clinicians are clearly seeing the increase in amputation and mortality risk for patients when DFU management is delayed, especially for patients with ischemia and infection. Health-care providers are learning to triage diabetic lower-extremity risk to determine which patients to see when, and with what level of urgency. This is extremely complex; some patients present with urgent, limb- or life-threatening wounds, while other patients with less urgent wounds benefit greatly from early intervention. These "less urgent" wounds can very quickly become urgent and life-threatening if the proper care is not put in place in a timely manner. In many cases, health-care providers must consider what level of risk is acceptable for people with diabetes and foot complications, and determine how to support prevention while also addressing acute need.

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Presentation Digest is a production of Wounds Canada (www.woundscanada.ca).

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