Feet First

“will thongs ever do?”
Thongs are part of the north Qld lifestyle: Will thongs ever do for people with diabetes?
» Overview of the diabetic foot
» Can we learn from overseas?
» Application to Queensland Health services
» Indigenous Diabetic Foot Program – resources for you
» Take home skills – risk assessment
Foot facts

In Australia in 2005, there were 1,001 diabetes deaths where lower limb ulcers were recorded as a cause of death. This accounted for 8% of all diabetes deaths\(^1\)

2011 it is estimated that 366 million people worldwide have diabetes, representing roughly 8.3% of the adult population\(^2\)

A leg being lost to diabetes somewhere in the world every 30 seconds – 2011 data suggests every 20 seconds\(^2\)

Majority of these amputations are preceded by ulcers. Only two-thirds of ulcers will eventually heal and the remainder may result in some form of amputation\(^2\)

Median time of healing for an ulcer is approximately six months\(^2\)

It is possible to reduce amputation rates by up to 85%\(^2\)
Consider the population of people with diabetes. How many people would have feet that are of:

» **Low Risk** - no evidence of peripheral sensory and/or arterial impairment\(^3\)

» **At Risk** - significant peripheral sensory and/or arterial impairment, but who have not had an episode of active foot disease\(^3\)

» **High Risk** - at least one previous episode of active foot disease (including those who have undergone a diabetes-related amputation)\(^3\)

» **Acute Risk** - current active foot disease\(^3\)
70% low risk of diabetic foot disease
risk of ulceration: 99.6% ulcer-free after 2 years

Adopted from *PODIATRY COMPETENCY FRAMEWORK FOR INTEGRATED DIABETIC FOOT CARE*
established risk factors for diabetic foot disease
risk of ulceration 3-7% per year

20%

70%

low risk

Adopted from PODIATRY COMPETENCY FRAMEWORK FOR INTEGRATED DIABETIC FOOT CARE ³
4 - 8% history of diabetic foot disease risk of ulceration 40 – 50% per year

20% at risk

70% low risk

Adopted from PODIATRY COMPETENCY FRAMEWORK FOR INTEGRATED DIABETIC FOOT CARE
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» If we consider prevalence of diabetes 4.4% of the population
» If Townsville has a population of 150,000
» 6,600 people with diabetes

If 8 in every 100 have diabetic foot ulcer
528 people have DFU each year in Townsville
Some clinical guidelines recommend every person with diabetes should have an *annual* foot check

6,600 people with diabetes, in Townsville

**RACGP recommends**[^4]:

» Patients need to know and practise routine foot care
» Check six monthly for factors predisposing to problems: reduced circulation or sensation, abnormal foot structure, poor hygiene
» High risk patients should be reviewed by a podiatrist
Queensland Health podiatrists will deliver evidenced-based, best practice clinical services for those people with:

- Lower limb amputations and ulcerations
- Peripheral Neuropathy or Peripheral Vascular Disease
- Gross Foot Deformities
- Falls risk

Low risk clients without any of the above defined complications will not be eligible for Podiatry services.
For the THHS, the podiatry service is focusing on core business. Diabetic Foot Assessments (DFA) will need to have been achieved prior to referring into our service. Referrals will be accepted for:

» Lower limb amputations and ulcerations
» Peripheral Neuropathy or Peripheral Vascular Disease
» Gross Foot Deformities
» Falls risk
Who will be doing the DFA?

Primary health care providers who are deemed competent in the assessment of the diabetic foot can undertake the diabetic foot check:

» Podiatrists
» Medical practitioners
» Practice nurses
» Aboriginal & Torres Strait Islander Health Workers
» Others
Queensland Health target client group

- 10% high/acute
- 20% at risk
- 70% low risk
QH Episode of Care, not for life!

Provide the management required – then discharge to the referrer

One of 528 DFU client’s
Since 2005, IDFP has been providing education and training to skill the health workforce in diabetic foot screening.

**DART (Diabetic foot Assessment of Risk Test) form**

1. Feel for foot pulses
2. Check for sensation
3. Identify foot lesions & deformity
4. Identify amputations and significant scars
5. Identify self care practices
Workshop time?

Foot pulses
Using the 10g monofilament
Locating foot pulses

If all 4 pulses are not palpable ➔ HIGH risk factor

Dorsalis pedis – top of the foot pulse

Posterior tibial pulse – inside ankle pulse
Use 10g Monofilament

If all 6 sites are not sensed ➔ HIGH risk factor
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» Thongs are a step up from barefeet
» Available and affordable
» Offer some protect from injury
» Offer protection from surface heat
» No protection to the dorsum of the foot
» .... A step in the right direction!
Before closing

» Review the Australian Diabetes Foot Network’s recommendations

» Review some of the evidence
Recommendations to improve national diabetes-related foot disease care

» National data collection on incidence and outcomes of diabetes-related foot disease (DRFD)
» Improved access to care, through the Medicare Benefits Schedule, for people with diabetes that have a current or past foot complication.
» Standardised national model for interdisciplinary diabetes-related foot care
» National accreditation of interdisciplinary foot clinics and staff
» Subsidies for evidence-based treatments for DRFD, including medical-grade footwear and pressure off-loading devices
» Holistic diabetes care initiatives to “close the gap” on inequities in health outcomes for Aboriginal and Torres Strait Islander peoples.
The first priority of management of foot ulceration is to prepare the surface and edges of a wound to facilitate healing. If foot pulses are present, non-viable tissue should be removed from the wound bed and surrounding callus removed using local sharp debridement.

Topical hydrogel dressings may be considered for autolytic debridement to assist the management of non-ischaemic, non-healing ulcers with dry, non-viable tissue.

There is insufficient evidence to demonstrate the superiority of any one wound dressing over another in management of ulcers. The dressing plan will need to be tailored to the specific characteristics of the wound.

Non-ischaemic ulcers, create a moist wound environment.

Ischaemic ulcers maintain a dry wound environment using a dry, non-adherent dressing, until the wound has been reviewed by someone with experience in peripheral arterial disease.
Pressure reduction, otherwise referred to as redistribution of pressure or offloading, is required to optimise the healing of plantar foot ulcers.

Offloading of the wound can be achieved with the use of a total contact cast or other device rendered irremovable.

Other removable offloading devices may be considered in particular settings (e.g. wounds that require more regular debridement and dressing changes) or where patient factors (e.g. significant risk of falls) do not allow the use of an irremovable device.

People with diabetes-related foot ulceration are best managed by a multi-disciplinary foot care team.
References

Thank you