

Diabetes Care for You



Sussex Community
NHS Foundation Trust

Risk Scoring of Diabetic Feet



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Excellent care at the heart of the community

Risk of What ?



Ulceration

At risk of having an active Diabetic foot problem



Charcot arthropathy



Spreading Infection



Critical Limb Ischemia



Gangrene

Why do we risk score ???

- Comply with NICE Guidelines
- Knowing who and when to refer to specialist service
- To guide health care teams on when to reassess
- Inform / educate the patient
- Prevent ulcerations
- Prevent amputations

Background

Diabetes is the most common cause of non – traumatic limb amputation, with diabetic foot ulcers preceding more than 80% of amputations in people with diabetes.

Mortality rates after a diabetic foot ulceration and amputation are high, with up to 70% of people dying within 5 years of having an amputation and around 50% dying within 5 years of developing a diabetic foot ulcer. This high mortality rate is believed to be associated with cardiovascular disease and emphasises the importance of good diabetic and cardiovascular management. NICE cg19 2015

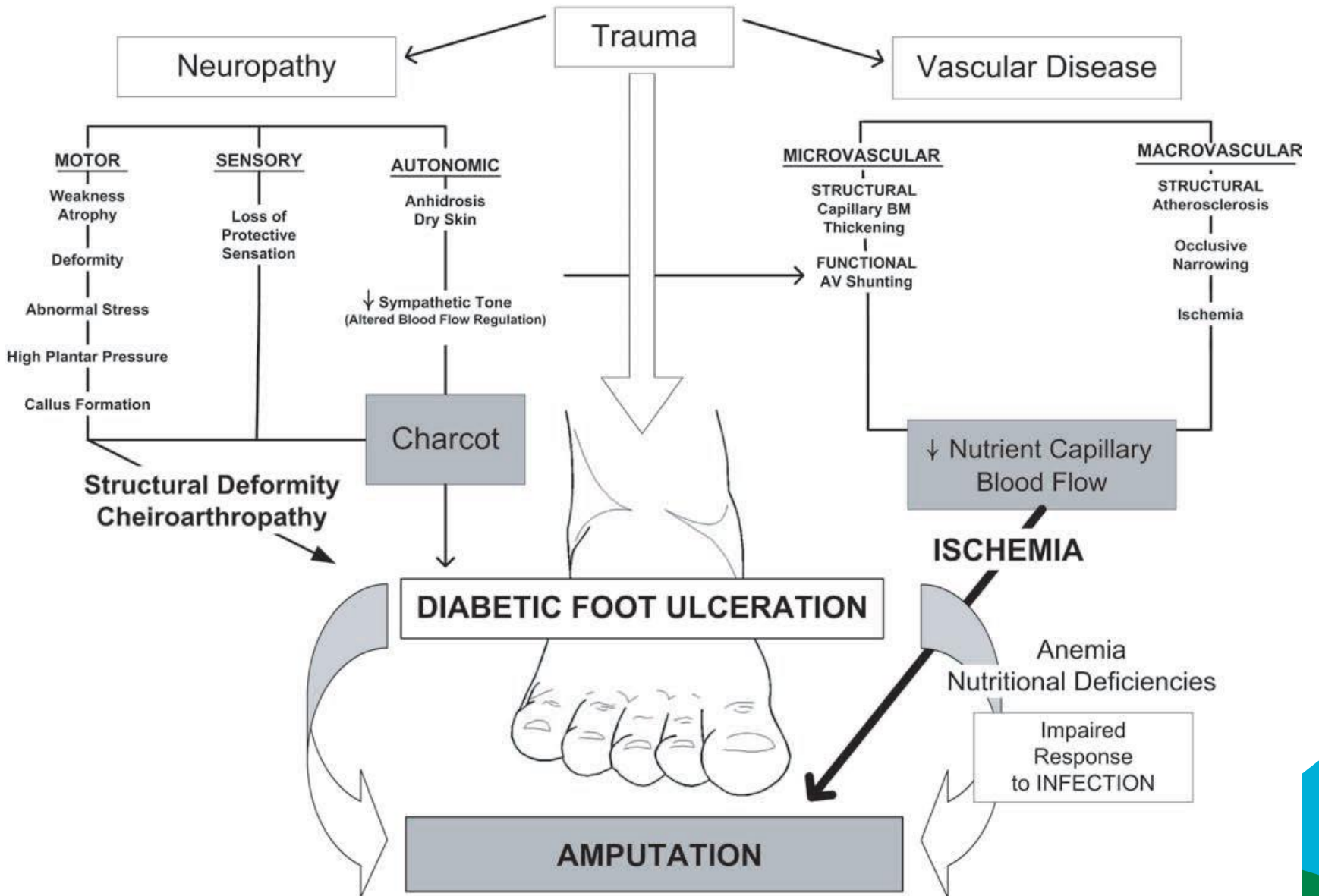
The risk of foot problems in people with Diabetes is increased. Why ?

Neuropathy (nerve damage or degeneration)

Peripheral arterial disease (poor blood supply due to diseased large and medium sized blood vessels in the legs)

Or both

DIABETES MELLITUS



Risk Factors



Neuropathy

Using a 10g monofilament as part of the foot sensory examination



Loss of protective sensation: Inability to sense light pressure e.g. as applied with a 10 gram monofilament – IWGDF Definitions and Criteria

Sensory Testing

The only piece of equipment that is required to carry out a simple, evidence based, foot screening is a 10g monofilament – (Frame)

First apply the monofilament on the patient's hand (or elbow or forehead) to demonstrate what the sensation feels like

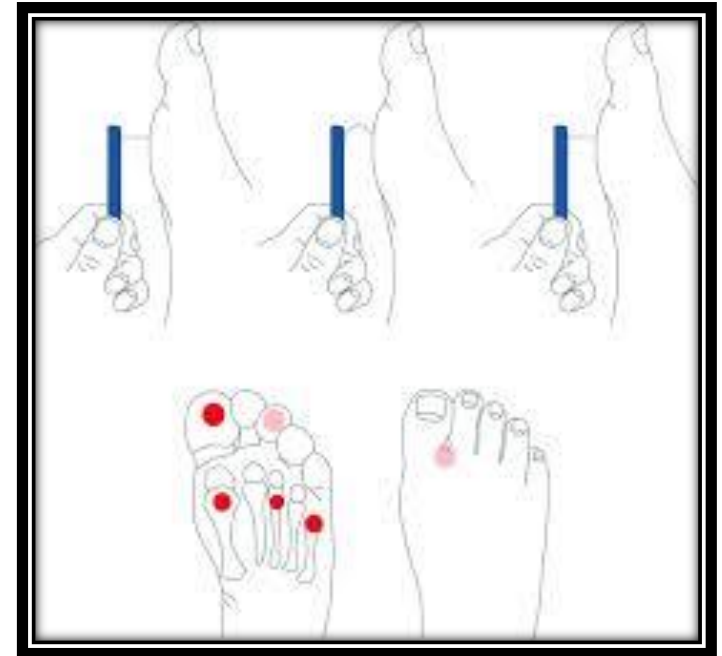
Apply the monofilament perpendicular to the skin surface.

Apply sufficient force to cause the filament to bend or buckle.

The total duration of the approach - skin contact and removal of the filament - should be approximately 2 seconds.

Apply the filament along the perimeter of, not on, an ulcer site, callus, scar or necrotic tissue.

Do not allow the filament to slide across the skin or make repetitive contact at the test site.



Test sites??

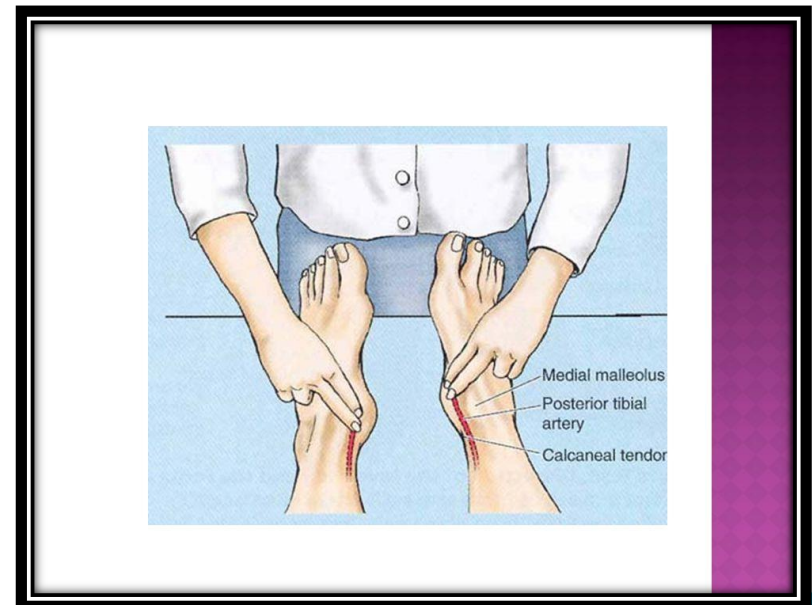
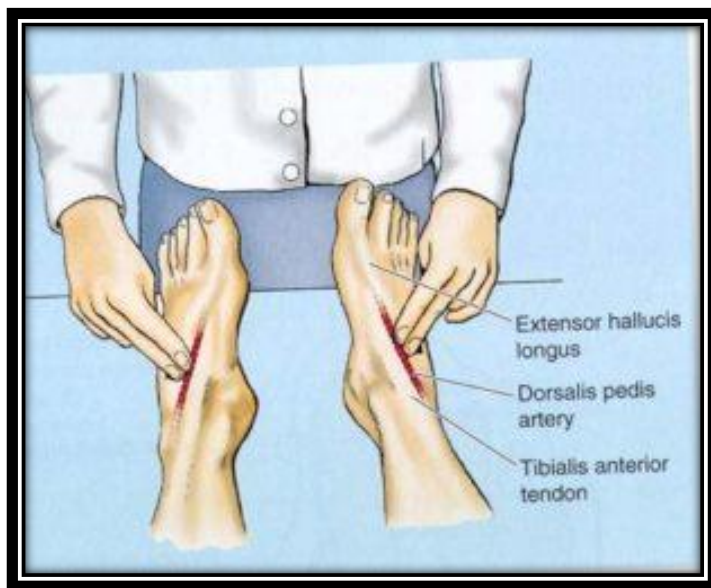


Non-critical limb Ischaemia

Assessment of Peripheral Arterial Disease in diabetes patients is complicated.

However there are some clinical tests / signs / symptoms that can help lead us towards or away from a diagnosis of PAD (non-critical limb Ischaemia)

If one foot pulse can be palpated and there are no other physical signs of lower limb arterial disease then PAD is unlikely



Symptoms and signs of PAD

- Intermittent Claudication
- Absent pulses
- Low ankle brachial pressure index
- Monophasic signal with doppler
- Skin changes (not always a feature)

Deformity

Structural abnormality of the foot



A non significant structural abnormality of the foot can be described as a very minor change of shape of the foot which does not result in areas of pressure, leading to callus formation, and a difficulty in fitting shoes which could be purchased in high street shops.

Callus



Previous ulceration

Previous ulceration is defined as an area that has previously been ulcerated but has subsequently healed. After ulceration the affected area never repairs itself completely and only returns to 70% of tensile strength. This area is always vulnerable to future ulcerations. Previous ulceration is the highest risk factor for future ulceration. (Frame)



Previous Amputation

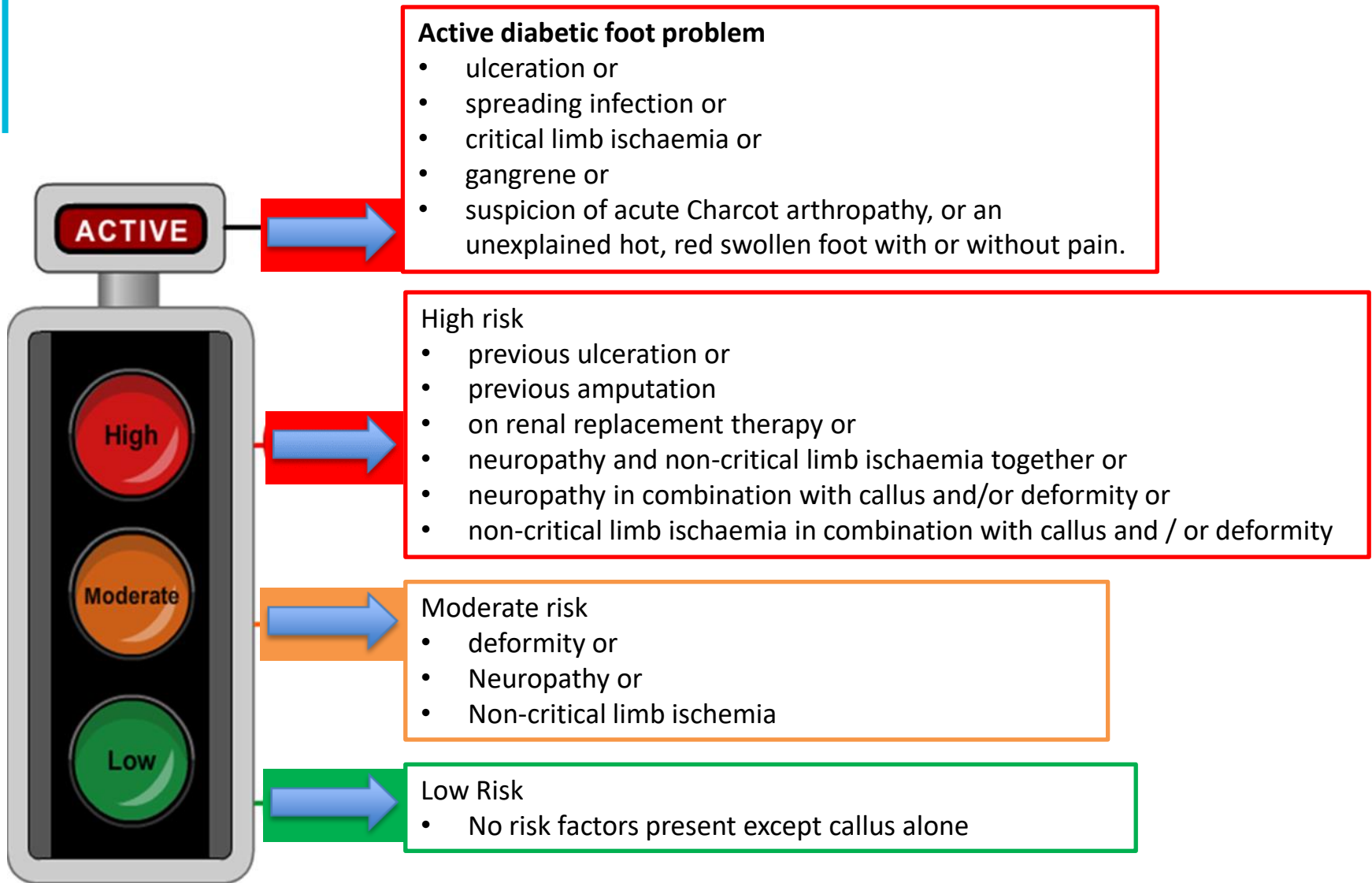


On renal replacement therapy

- High risk – ng 19
- High risk – IWGDF

Adding up the risks





**Thank you all for
listening.
Questions ?**