DIABETIC FOOT CASE REPORT

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EPIDEMIOLOGY

- **The Diabetic foot constitutes a tremendous challenge for patients, caregivers and health care systems**
- **During their lifetime one in seven diabetic patients develops foot ulcers which are highly susceptible to infection**

- **85% of amputations are preceeded by an ulcer**
- **The diabetic foot treatment expenses absorb about 40% of overall hospital budget for diabetes**

Lavery L.A. et al., Diabetes Care, 19:48, 1996

-DFI treatment accounts for up to one-quarter of all diabetic admissions in both Europe and the United States making it the single **most common reason for DM-related hospital admission.**

-Approximately two third of lower extremity amputations are the result of an infected ulcer

-Surgery as a part of a multidisciplinary approach is a key in the management of many types of diabetic foot infections (DFIs)

Pecoraro RE *Diabetes Care* 1990
Apelqvist J et al *Foot Ankle Int 1995*
Armstrong DG *Diabetes Care* 1998
Boulton AJ et al *Wound Repair Regen 1999*
Lipsky BA et al *Clin Infect Dis 2004*
Lavery LA et al *Diabetes Care 2006*

International Journal of Infectious Diseases
journal homepage: www.elsevier.com/locate/ijid

Review

Diabetic foot infections: what have we learned in the last 30 years?

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Table 1
Key changes in the knowledge and management of diabetic foot infections in the last 30 years—summary of the authors' views

Research field	1985	2015
Pathogens	Methicillin-susceptible *Staphylococcus aureus*, streptococci, *Enterobacteriaceae*	More multidrug-resistant organisms (MRSA, ESBLs) Predominance of Gram-negative pathogens in (sub)tropical climates
Microbiological diagnosis	Standard cultures, usually of swab specimens	Aerobic and anaerobic cultures of tissue specimens (soft tissue and bone) Molecular microbiology (e.g., PCR) Metagenomics
Imaging	Plain X-rays; scintigraphy (bone, leukocyte scans)	MRI; SPECT/CT; PET/CT
Antibiotic agents	Penicillins; 1st to 3rd generation cephalosporins; some 2nd generation fluoroquinolones	4th/5th generation cephalosporins; carbapenems; 3rd/4th generation fluoroquinolones; linezolid; daptomycin
Route of administration and site of treatment	Initial (sometimes prolonged) intravenous administration, usually in hospital	Mostly oral (sometimes after a brief intravenous course), even in the presence of vascular disease or osteomyelitis; some topical; outpatient except for severe infections or complex treatments
Spectrum of antibiotic therapy	Relatively broad (directed at Gram-positive and Gram-negative pathogens)	Very broad empiric therapy for severe infections; more targeted for mild/moderate infections and for definitive therapy
Duration of antibiotic therapy	Many weeks for soft tissue infections; ≥6–12 weeks for bone	1–2 weeks for soft tissue infections; 4–6 weeks for osteomyelitis
Surgical approach	Aggressive (ablative) therapeutic surgery; inpatient treatment	More conservative (tissue sparing) therapeutic (even for osteomyelitis) and preventive surgery; corrective surgery; often in outpatient facilities and specialized diabetic foot centres
Revascularization	Open vascular surgery	More percutaneous angioplasty and distal bypasses, including infragenicular
Management guidelines	Mostly individual, empirical approaches Individual recommendations and practices on the hospital level	Clinical guidelines based on systematic reviews; multidisciplinary teams, especially including podiatry; clinical pathways; some behavioural sciences national guidelines; validation of guidelines
Adjunctive treatments	Stimulation with growth factors; platelet-rich products; larval biotherapy (maggots)	Hyperbaric oxygen therapy; granulocyte-stimulating factors; research in stem cell and bacteriophage therapies; microbiome concepts
Dressing	Simple dressings, with separate use of disinfection agents	More hydrofibre and silver-containing dressings; studies with topical antibiotics embedded in dressings
Scientific publications	Mostly case series	More prospective randomized trials, multicenter studies, and evidence-based (Cochrane) meta-analyses

ESBL, extended-spectrum beta-lactamase; MRI, magnetic resonance imaging; MRSA, methicillin-resistant *Staphylococcus aureus*; PET/CT, positron emission tomography/computed tomography; SPECT/CT, single photon emission computed tomography/computed tomography.

CASE HISTORY

- F.F. Male 78 yrs old
- Type 2 Diabetes (insulin/Dapaglifozin)
- Stroke (2004)
- CHD (CABG 2023)
- Atrial Fibrillation (rivaroxaban)
- Diabetic Retinopathy (vitrectomy 2018)
- Charcot Neuroarthropathy class 2 Frykberg & Sanders left foot (midfoot fusion 2022)

CASE HISTORY

- December 2023 a new lesion on the plantar aspect right hindfoot
- Admitted January 29 2024 in DF Department MCH Cotignola Italy

Differential Diagnosis:

Osteomyelitis?

Acute Charcot Neuroarthropahty class 5?

Vascular Assessment at Hospital Admission

- $TcPO_2$ right foot 19 mmHg
- Duplex Scanning: occlusion of Anterior and Posterior Tibial Arteries

Surgical Procedure (1) January 30th 2024

- Surgical debridement of soft tissue
- Exposition of calcaneal fracture
- Bone biopsy for micro and histo evaluation
- Microbiological results on bone biopsy:
  - **Proteus mirabilis**
  - **Staph epidermidis MR**
  - **Enterococcus faecalis**

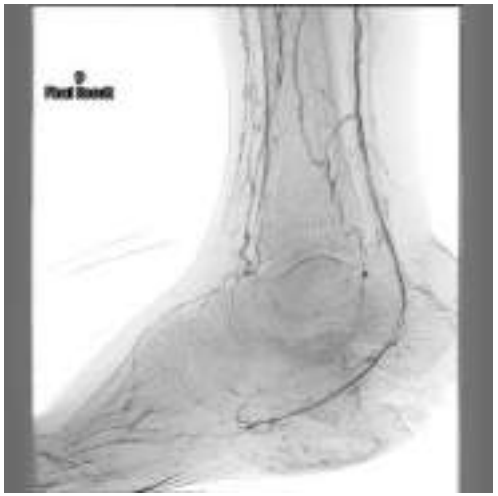
AngioPTA January 31 2024

- Extensive BTK disease



AngioPTA January 31st 2024

- PTA posterior tibial artery and plantar artery
- PTA proximal anterior tibial artery (ineffective treatment in distal artery)



Surgical Procedure (2) February 1st 2024

- Calcanear wedge osteotomy
- Reduction of the fracture and application of ALBS
- Stabilization of the hindfoot with external fixation
- After bleeding control NPWT plus antiseptic (polyhexanide) instillation has been started

EXTERNAL FIXATION

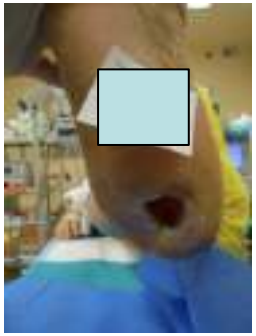
- External fixation for midfoot/hindfoot reconstruction and stabilization offers a versatile alternative when internal fixation is not feasible
- The use of transosseous wires provides increased stability with compression of the desired osteotomy and/or joints to obtain bone healing while allowing total offloading of the surgical site
- At the same time immediate partial weight bearing status in certain cases is allowed
- The surgical site is easily inspected

Surgical Procedure (3) february 27th 2024

- Surgical debridement
- Application of dermal substitute

Surgical Procedure (4) May 27th 2024

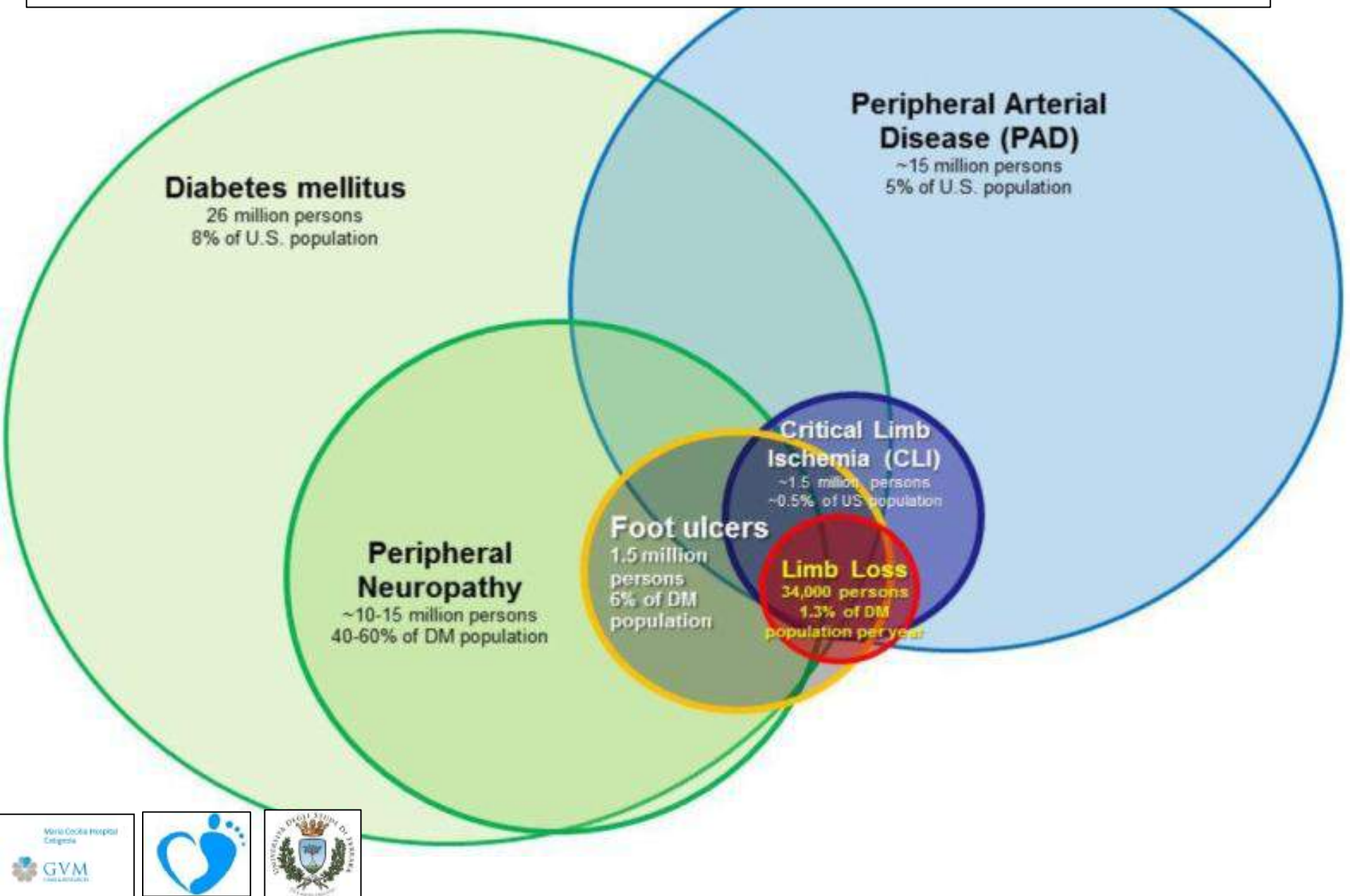
- Autologous skin graft



Secondary Prevention Protocol from july 2024

Take Home Messages

THE OVERLAPPING RELATIONSHIP OF RISK FACTORS ASSOCIATED WITH NON-TRAUMATIC LIMB LOSS IN THE US. ESTIMATES OF TOTAL AFFECTED US POPULATION, US PREVALENCE AND ANNUAL INCIDENCE RATES ARE SHOWN



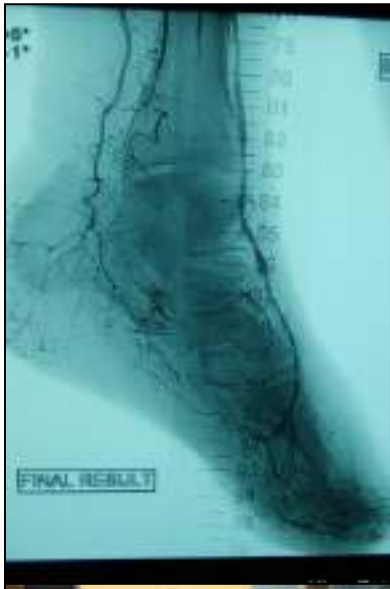
Current Diabetes Reviews, 2006, 2, 431-447 431

Treatment of Diabetic Foot Ulcer: An Overview Strategies for Clinical Approach

Luca Dalla Paola* and Ezio Faglia*

Keypoints for avoiding amputations

- **Relief of plantar pressure in the treatment of neuropathic plantar ulcer**
- **Revascularisation procedures**
- **Emergent treatment of infected diabetic foot**
- **Surgery of the chronic diabetic foot (ostemyelitis)**
- **Surgery of instability and deformity (Neuropathic foot/Charcot foot)**
- **Advanced local therapy (NPWT, Bioengineered tissues, exfix)**
- Patient education and compliance
- Diabetes control
- Control of CV risk factors



- Heel ulcers result from a combination of chronic pressure, neuropathy, and PVD

- Unlike lesions located at forefoot and midfoot levels, **hindfoot and calcaneal lesions have a poor healing rate even in the case of sufficient vascular supply and consecutive to aggressive debridement associated with adequate antibiotic therapy**

- Despite difficulties in obtaining a successful conservative treatment, several clinical studies have shown the possibility to obtain limb salvage

Randall DH, Philips J, Isiorio G. Partial calcanectomy for the treatment of recalcitrant heel ulceration. J Am Podiatr Med Assoc 2000;90:359–65.

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Benvenisty R, Menendez NM, Weinhaimer DJ, Lowery C, Krasnovich R, Vidt L. Subtotal calcanectomy for the treatment of large heel ulceration and calcaneal osteomyelitis in the diabetic patient. J Foot Ankle Surg 1999;38:194–202.

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Treiman GS, Oderich SC, Ashrafi A, Schneider PA. Management of ischaemic heel ulceration and gangrene: an evaluation of factors associated with healing. J Vasc Surg 2000;31:1118–25.

Uzunes NA, Alhezel AM, Awad H. Diabetic heel ulcers: a major risk factor for lower extremity amputation. Ostomy Wound Manage 2004;50:50–61.

Cavera JJ, Bilton LL, Kerstein MD. Options for diabetic patients with chronic heel ulcers. J Diabetes Complications 1997;11:358–366.

Clinical and Translational Research

Combination of Open Subtotal Calcanectomy and Stabilization With External Fixation as Limb Salvage Procedure in Hindfoot-Infected Diabetic Foot Ulcers

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(a)

(b)

Table 1. Characteristics of the Population Studied.

Characteristics	Total Population (N = 18)
Male/female, n	17/1
Type 1/2 DM, n	1/17
Age (years), mean ± SD	65.7 ± 8.2
CHD (history), n (%)	13 (72.2)
GFR (mL/min)	
>90	4
60>89	4
30>59	8
<30	2
Wound stage III TUC, n (%)	18 (100)
Mean wound area (cm^2), mean ± SD	6.7 ± 4.1
PVD, n (%)	13 (72.2)
PTA, n (%)	10 (55.6)
Bypass, n	0

Abbreviations: DM, diabetes mellitus; CHD, coronary heart disease; GFR, glomerular filtration rate; TUC, Texas University Classification; PVD, peripheral vascular disease; PTA, percutaneous transluminal angioplasty.

Inclusion criteria were the following:

1. Ulcer area ≥4 cm^2
2. Score lesion IIIB-D using University of Texas Classification
3. Clinical evidence of soft tissues infection
4. MRI/SPECT-CT (magnetic resonance imaging/single-photon emission computed tomography) positive for calcaneal osteomyelitis
5. Transcutaneous oxygen pressure measured on foot ≥30 mm Hg.

CONCLUSIONS

- DFO require rapid multidisciplinary team assessment.
- Use of bone culture, histology, MRI is recommended, but osteomyelitis can be difficult to objectively diagnose.
- Osteomyelitis is not an indication for primary amputation
- Spreading or deep diabetic foot infections likely require surgical inpatient management
- The goal of therapy is to prevent amputation and to preserve as much of the weight bearing surface as possible.
- Vascular assessment and liberal revascularization are imperative to a successful outcome in treating a diabetic foot infection.

Thank you for your attention