NHS TAYSIDE WOUND MANAGEMENT FORMULARY

Section 7: FOOT ULCERS

Type	Indicator/descriptor	Management aims	Treatment Options		Other Considerations
			1st line	2nd line	
Necrotic 	Necrotic layer of devitalized tissue May be black/brown May be soft/hard May produce offensive odour	Rehydration and removal of necrotic tissue	If vascular insufficiency or if wound requires sharp debridement contact **wound management/diabetes specialist podiatrist:** See Tissue Viability Pathway		Patients with active diabetic foot disease should be referred to podiatry, see Tayside Diabetes MCN Handbook Screening and Management of Foot Complications – **Click Here** Assess vascular status to ensure adequate blood supply. Refer to vascular service if: - ischaemic tissue loss - pain at rest Wounds should be closely monitored and dressing changed regularly. Debride necrotic/dead tissue using the most suitable form of wound debridement. Sharp debridement should only be carried out by appropriately trained practitioners. **Dressings used to rehydrate wounds, e.g. Flaminal Hydro should be applied cautiously to patients with limb ischaemia or dry gangrene. Dry gangrene can rapidly progress to wet gangrene with serious consequences.** Dry gangrene should be kept as dry as possible especially at the line of demarcation with sharp debridement to this area to remove dead material. If patient has loss of protective sensation then regular wound inspection is required to detect any changes. It is important to check the wound for signs of infection – **Please note the clinical signs of infection may be absent in patients with neurological deficits.** Avoid occlusive dressings on infected wounds. Offload pressure from wound site – please see **NHST guidance for the use of small devices in the treatment and prevention of grade 1 pressure ulcers** (Docstore link) For guidance on dressing selection for infected wounds see section 12: Wound Infection. For systemic treatment of wound infection refer to the Tayside Area Formulary Primary Care Antibiotic Man or Diabetes handbook for information on antibiotic choice. **Notes**: If patients is on Biologics or Methotrexate and you suspect infection, contact patients GP or Biologics Specialist Nurse for advice as temporary withdrawal may be required. Soft silicone foam dressing are the preferred choice on the foot as they effectively mould and conform to uneven contours, provide thermal properties and provide protection from footwear for bony vulnerable areas. **References:** 1. NHS Tayside Diabetes Managed Clinical Network Handbook - click here 2. **36** Wound Essentials 2016, Vol 11 No 1 3. www.nice.org.uk/guidance/ng19 4. Foot Ulcer management in the Community – **36** Wound Essentials 2015, Vol 10 No 1
			Flaminal Hydro	**Honey** Medihoney	
			Secondary dressing **Soft Silicone Foam**		
Sloughy 	Layer of dead tissue May be yellow/green Dry or Wet May produce offensive odour	To remove all debris	**Flaminal** Forte-wet/Hydro-dry	**Honey** low/mod exudate **hydrofibre-** High	
			Fibrous hydrocolloid with foam If moderate to high exudate **Do not occlude**		
			Secondary dressing Not required with fibrous hydrocolloid with foam dressing **Soft Silicone Foam**		
Granulating 	Wound has 'granular' appearance and looks red and moist	Protect from trauma and maintain moist, warm environment	**Soft Silicone Foam** If wound infection suspected consider an antimicrobial dressing see section 12		
Epithelialising 	Red/pink, new skin cover extending from wound edges, may have islands of new epithelium in main areas of the wound bed	Protect and maintain optimal wound healing environment	**Soft Silicone Foam**		

Updated: 17 May 2021