Section 9: Foot Ulcers

<table>
<tr><th>Type</th><th>Indicator/descriptor</th><th>Management aims</th><th colspan="2">Treatment Options</th><th>Other Considerations</th></tr>
<tr><th></th><th></th><th></th><th>1st line</th><th>2nd line</th><th></th></tr>
<tr>
<td rowspan="3">Necrotic
</td>
<td rowspan="3">Necrotic layer of devitalized tissue
May be black/brown
May be soft/hard
May produce offensive odour</td>
<td rowspan="3">Rehydration and removal of necrotic tissue

DO NOT rehydrate or remove until vascular status confirmed</td>
<td colspan="2">If vascular insufficiency exists or if wound requires sharp debridement contact
Podiatry Department on
tay.taysidepodiatry@nhs.scot
as per Section 15: Referral Pathway</td>
<td rowspan="3">Patients with active diabetic foot ulceration 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 urgently to vascular service if: - Ischaemic tissue loss
- Pain at rest
- Critical Limb Ischaemia (CLI)

See: Section 15: Referral Pathway

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 should be applied cautiously to patients with limb ischaemia. . Ensure vascular assessment completed.

Dry gangrene should be kept as dry as possible especially at the line of demarcation, Dry gangrene can rapidly progress to wet gangrene with serious consequences

Wounds should be closely monitored and dressing changed regularly, especially if no protective sensation. Link to podiatry wound care patient leaflet - http://staffnet.tayside.scot.nhs.uk/NHSTaysideDocs/groups/pil/documents/documents/prod_263746.pdf

It is important to check the wound for signs of infection. For guidance on dressing selection for infected wounds see Section 5: Wound Infection

Avoid occlusive dressings on infected wounds.

<u>Please note the clinical signs of infection may be absent in patients with, for example, neurological deficits, or immunosuppression.</u>

<u>NOTE: If patient is on Biologics, DMARDS or Methotrexate and you suspect infection, always swab wound and contact pts GP or Biologics specialist nurse for advice as temporary suspension may be required.</u>

<u>For systemic treatment of wound infection refer to the Tayside Area Formulary – Antibiotic man (Primary care or Hospital)</u>

Offload pressure from wound site – please see Pressure Ulcer Section 6 of WMF.

CPR for Feet

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.

<u>References:</u>

1. NHS Tayside Diabetes Managed Clinical Network Handbook - click here

2. Dabiri G, Damstetter E, Phillips T. Choosing a Wound Dressing Based on Common</td>
</tr>
<tr><td>If requiring to hydrate necrotic tissue options are:
Flaminal Hydro
Honey – L Mesitran ointment</td><td>If not rehydrating, may not need covered – if required use dry or non adherent dressing to protect</td></tr>
<tr><td colspan="2">Secondary dressing if rehydrating

Soft Silicone Foam (Kliniderm Foam)</td></tr>
<tr>
<td rowspan="3">Sloughy
</td>
<td rowspan="3">Layer of dead tissue
May be yellow/green
Dry or Wet
May produce offensive odour</td>
<td rowspan="3">To remove all debris</td>
<td>Flaminal Alginate Gel

Forte- mod-high exudate
Hydro-low to mod exudate</td>
<td>Honey dressing

Mod-high exudate</td>
</tr>
<tr><td colspan="2">Hydrofibre (Aquacel Extra)

If moderate to high exudate
Do not occlude</td></tr>
<tr><td colspan="2">Secondary dressing

Soft Silicone Foam</td></tr>
<tr>
<td>Granulating
</td>
<td>Wound has 'granular' appearance and looks red and moist</td>
<td>Protect from trauma and maintain moist, warm environment</td>
<td>Kliniderm Lite low exudates only</td>
<td>Soft silicone foam</td>
</tr>
<tr><td colspan="5">NO ANTIMICROBIAL DRESSING REQUIRED FOR GRANULATING WOUNDS – ANTIMICROBIAL STEWARDSHIP.</td></tr>
<tr>
<td>Epithelialising</td>
<td>Red/pink, new skin cover extending from wound edges, may have islands of new epithelium in main areas of the wound bed</td>
<td>Protect and maintain optimal wound healing environment</td>
<td>Lite silicone foam</td>
<td></td>
</tr>
</table>

				Wound Characteristics. Adv Wound Care (New Rochelle). 2016 Jan 1;5(1):32-41. doi: 10.1089/wound.2014.0586. PMID: 26858913; PMCID: PMC4717498. 3. Aamir, Nasrullah & Publication, Professional & Kumar, Nuresh & Memon, Gulshan. (2020). Diabetic foot ulcer, risk factors and managment: A literature review. 10. 157-162. 10.46536/jpumhs/2020/10.02.247. 4. International Best Practice Guidelines: Wound Management in Diabetic Foot Ulcers. Wounds International, 2013. Available from: www. woundsinternational.com 5. Diabetes Metab Res Rev. 2020;36(S1):e3276. https://doi.org/10.1002/dmrr.3276 6. Foot Ulcer management in the Community – 36 Wound Essentials 2015, Vol 10 No 1