



MANAGEMENT OF THE DIABETIC FOOT

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The tissue defect of the diabetic foot represents a special challenge as one of the momentous complications of the diabetes mellitus. The clinical picture expresses oneself as polyneuropathy, peripheral arterial occlusive disease (PAOD) or as a mixed form of both pictures. Approx. 40-60% of all non-traumatological amputations of the lower legs are performed at patients with diabetes, who have in 85% of all cases suffered a "harmless" foot lesion. Typical localisations for the occurrence of damages are neuropathical ulcers at heel, sole and metatarsale I.- or V.-bone-head.



Frequently large areas of skin lesions develop due to the reduction of the perception of thermal excitements.



Thermal lesion before and after treatment

Following the guidelines of the conference of St. Vincent, in spite of longterm pre-treatments, the frequency of amputation of the lower limb should be reduced and a better quality of life should be reached using the preserved extremity.

This goal is only reached by a long-term elaborated treatment under stationary conditions including adjuvant antibiotic and vasoactive medicament therapy.

Additionally before any surgical treatment a conditioning, phase-correlated wound treatment with modern wound therapeutics is required, which has to be performed during the whole process.

Therapy

The treatment conception of our clinic determines to perform a sufficient debridement - surgical or pharmacological - of necrotic tissue with long-term (tested) antibiotic therapy 6-12 weeks or more, temporary immobilisation and stabilisation of diabetic situation. Thereafter a functional therapy concept will be created with the goal to preserve as much as possible parts of the affected extremity after the IRAS-principle (anti-infective therapy, revascularisation, amputation, training). The wound area has to be managed in terms of moist wound treatment and conditioned under occlusion and protection by Polyurethan-membrans in combination with timely use of hydroactive and collagen materials, like for instance the Suprasorb®-system (Lohmann&Rauscher).

Under the aspect to reach as high stability as possible an occlusion of the defect follows by normally using skin grafts and accurate skin care.

After total healing the foot has to be provided with individually made and well padded footwear.

Conclusion

The results of therapy surely will not lead to a permanent reconstruction of the problematic wound area but can retard fatal operational methods like amputation and can provide a better quality of life for a certain amount of time. Just the complicated mixed forms of PAOD and polyneuropathy represents a severe clinical picture with bad prognosis due to high recurrence rate of initially healed defects: 5 years after amputation only 27% of the patients are alive.