With 5% of the diabetic population, Champagne-Ardenne is one of the most affected by diabetes French regions. The diabetic foot is well represented and becomes a real public health problem.

Two processes causes foot ulceration in diabetic patients often intertwined: neuropathy and peripheral arterial disease. Present in 90% of cases of sensory neuropathy causes a delay of consultation, poor adherence to treatment and there is neglect on the part of the patient and sometimes the caregiver.

The initial assessment of the wound is essential to identify a strategy that will support multi necessarily professional. The metabolic balance, infection, discharge, arterial and local care: here are five essential points of the expertise of a diabetic foot wound.

Place of orthopedic surgery in the management must be redefined and considered supplemental to and not as a failure of medical treatment. In the hands of an experienced surgeon, the conservative surgical procedures on soft tissue during hypodermitis for example (excision of infected tissue drainage) and bone-conserving surgery during ostitis most often prevent amputation all reducing the healing time and antibiotics.

These surgeries cannot disrupt a major way the architecture of the foot and should strive to maintain functionality and avoid exposure to excess risk of recurrence (hyper side support). This surgical care, rarely urgent, must be done in close consultation between physicians and surgeons.

Each healthcare professional is concerned and must participate in a consistent and appropriate care of this disease in order to reduce the number unfortunately stagnant amputation.

Further reading


http://dx.doi.org/10.1016/j.rehab.2013.07.204

CO12-003-e

Treatment of diabetic foot ulcers in a multidisciplinary team: A prospective study of 304 cases with follow-up of 1 year

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Introduction.– The poor results of healing and high rate of amputation of diabetic foot ulcers come from a poor management of the treatment. We studied the management in our diabetic foot department of 304 new diabetic foot ulcers with a follow-up of 1 year.

Patients and methods.– We included 347 patients from July 2009 to December 2010. All patients were admitted in our diabetic foot unit. The management was multidisciplinary: diabetologist, physiatrists, radiologist, vascular surgeon, orthopaedic surgeon, nurses, physiotherapist. Amputation rate, healing rate and death rate were analysed after 1 year of follow-up.

Results.– We had 12% of lost in follow-up. We followed 304 patients during 1 year. Average age was 65, sex-ratio 2.2, 69% men, BMI 28.5 kg/m², average age of diabetes 18.7 years. Average age of ulcers was 157 ± 392 days.

We used the Classification of UT of the diabetic foot ulcers:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Total (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>57</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>B</td>
<td>5</td>
<td>9</td>
<td>29</td>
</tr>
<tr>
<td>C</td>
<td>60</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>D</td>
<td>21</td>
<td>15</td>
<td>67</td>
</tr>
<tr>
<td>143</td>
<td>58</td>
<td>103</td>
<td>304</td>
</tr>
</tbody>
</table>

After 1 year, decrease rate was 9%, amputation rate: below-knee: 5.7%, above-knee: 1.4%, chopard: 0.7%, lisfranc: 6.1%, transmetatarsal: 6.1%, toe: 11.5%. Healing rate was 67% (108 ± 40 days).

Survival rate with healing ulcers without amputation was: 59.4%. Multidisciplinary management of diabetic foot ulcers allows to get a good healing rate and a weak amputation and decease rate. It allows to decrease the major amputation rate.

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Complex neurorehabilitation programme improves quality of life of patients with diabetic polyneuropathy and diabetic foot