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 hypodermatitis for example (excision of infected tissue drainage) and bone-conserving surgery during osteitis 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

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CO12-002-e
Equipment of diabetic foot
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Keywords: Foot diabetic; Wounds; Discharge; Removable devices; Irremovable devices; Amputation

Risk diabetic foot imposes implementation of precautionary measures to avoid the appearance of a wound, to avoid its recurrence, and curative measures in case of ulceration. Mechanical origin is most frequent mechanism and need discharge by eliminating hyper-pressure exercises. It is essential to obtain the healing. The realized discharge avoids the mechanical trauma at the origin of the delay of healing having an essential role in the arisen of complications. Two systems of discharge are available: the irremovable devices validated by clinical trials and which bring better results by insuring a forced compliance, and the removable devices are mostly very used mass or custom-made by specialized centers.

To be able to unload wounds among which the locations, the areas and the depths are very variable, the equipment must be particularly individualized. The realization of removable orthoses on molding allows to preserve the profits of a moderated walking by respecting the hurt zones and by authorizing the access for the local care.

While we are in the presence of often asymptomatic ulcerations, it is imperative that the equipment constitutes a proportioned answer so that it is systematically worn from the first step.

The good observance as for the port of the removable devices is an imperative condition.

The forecast of the diabetic foot is dominated by the risk of an amputation; this one, when it will have become inevitable, will be realized after multidisciplinary opinion and will have to take into account possibilities of equipment, allowing the patient to obtain the best functional state.

Further reading

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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:

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After 1 year, decease 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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CO12-004-e
Complex neurorehabilitation programme improves quality of life of patients with diabetic polyneuropathy and diabetic foot