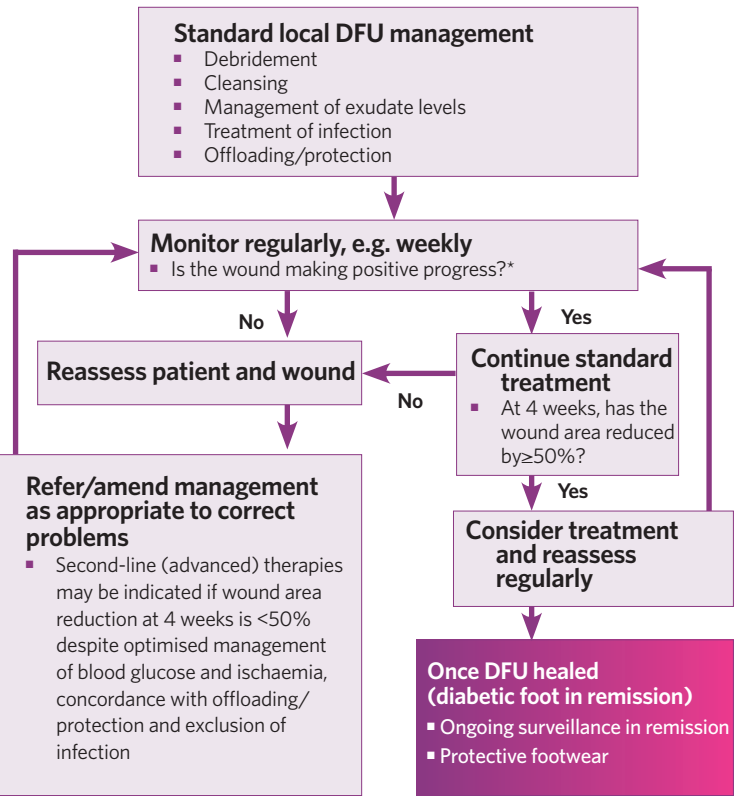


Principles of local management of DFUs¹



*Triggers for reassessment include increasing wound size, new pain or discomfort, signs of infection

References
 1. WUWHS. Florence Congress, Position Document. Local management of diabetic foot ulcers. *Wounds International*, 2016
 2. Boulton AJM et al. *Diabetes Care* 2008; 31(8): 1679-85
 3. Miller JD et al. *J Fam Pract* 2014; 63(11): 646-56
 4. Chadwick P, Armstrong DG. Local management of diabetic foot. *Made Easy*. *Wounds International*, 2017
 5. Téot L et al. *Int Wound J* 2017; 14(5) 842-8

Indications for referral of a patient with diabetes to a specialist foot service^{2,3}

Priority	Indications	Timing of consultation or referral	Suggested frequency of follow-up*
Urgent (active pathology)	<ul style="list-style-type: none"> Open wound +/- signs of infection New neuropathic pain or pain at rest Active Charcot deformity (red, hot swollen midfoot or ankle) Vascular compromise (sudden absence of DP/PT pulses or gangrene) 	Immediate consultation	As determined by specialist
High (ADA risk category 3)	<ul style="list-style-type: none"> Previous history of DFU or lower extremity amputation Chronic venous insufficiency 	Immediate or 'next available' outpatient consultation	Every 12 months
Moderate (ADA risk category 2)	<ul style="list-style-type: none"> PAD +/- LOPS DP/PT pulse diminished or absent Lower limb swelling or oedema 	Referral within 1-3 months	Every 2-3 months
Low (ADA risk category 1)	<ul style="list-style-type: none"> LOPS +/- longstanding non-changing foot deformity Patient requires specialist footwear 	Referral within 1 month	Every 4-6 months
Very low (ADA risk category 0)	<ul style="list-style-type: none"> No LOPS or PAD Education about foot care, exercise, footwear, preventing injury, etc. 	Referral within 1-3 months	As a minimum, annually

*All patients with diabetes should be seen by a foot specialist at least once per year. ADA: American Diabetic Association; DP: dorsalis pedis; LOPS: loss of protective sensation; PAD: peripheral arterial disease; PT: posterior tibial

QUICKGUIDE

Local management of diabetic foot ulcers



Management of diabetic foot ulcers is complex, and requires a multi-disciplinary team approach to avoid serious and expensive complications, such as infection and amputation!



LOCAL MANAGEMENT OF DFUs^{1,4}

Dry, black
(due to ischaemia)

Sloughy
Yellow, brown, grey or black

Granulating
Clean, red

Mostly or completely epithelialised
Red, pink

Cleanse: according to local protocol. V.A.C. VERAFLOR CLEANSE CHOICE™ Dressing provides a wound cleansing option for clinicians when surgical debridement must be delayed or is not possible or appropriate⁵

Debridement (as appropriate), e.g. for removal of callus and devitalised tissue

Primary dressing

To separate toes without retaining moisture or hydrating tissues:
ADAPTIC TOUCH™ Non-Adhering Silicone Dressing

Dry to low exudate

- TIELLE™ Lite
- Hydropolymer Adhesive Foam Dressing with LIQUALOCK™ Technology
- TIELLE™ Non Adhesive Dressing
- NU-GEL™ Hydrogel with Alginate

Moderate to high exudate

- BIOSORB™ Gelling Fibre Dressing
- TIELLE™ Plus Hydropolymer Adhesive Foam Dressing with LIQUALOCK™ Technology
- TIELLE™ Non Adhesive Dressing
- Use low adherent dressings below if appropriate: ADAPTIC TOUCH™ Dressing
- Consider skin barrier
- V.A.C. VERAFLOR CLEANSE CHOICE™ Dressing

Dry to low exudate

- ADAPTIC TOUCH™ Dressing

Moderate to high exudate

- BIOSORB™ Gelling Fibre Dressing
- TIELLE™ Plus Dressing
- TIELLE™ Non Adhesive Hydropolymer Dressing with LIQUALOCK™ Technology
- Use low adherent contact layer with dressings above if appropriate: ADAPTIC TOUCH™ Dressing
- Consider skin barrier

Protect new tissue growth to allow wound maturation and prevent from drying out

- ADAPTIC TOUCH™ Dressing
- Emollient
- Reassess regularly
- Ensure ongoing surveillance
- Provide protective footwear
- NU-DERM™ Thin Hydrocolloid Wound Dressing

If there is a risk of infection, consider an iodine-impregnated dressing, e.g. INADINE™ (PVP-I) Non Adherent Dressing

Deep wounds: BIOSORB™ Dressing or TIELLE™ Packing Dressing**; NPWT: V.A.C.® Therapy System (V.A.C. ULTA™ Therapy System and ACTIVA.C.™ Therapy System)

Infection: SILVERCEL™ Dressings†; V.A.C. VERAFLOR™ Therapy in conjunction with good clinical practice such as antibiotic therapy and debridement

Odour: consider a dressing containing activated charcoal, e.g. ACTISORB™ Silver 220 Activated Charcoal Dressing with Silver

Fragile periwound skin: TIELLE ESSENTIAL™ Silicone Foam Dressings or TIELLE™ Non Adhesive Dressing

Reassess the wound, periwound skin and suitability of the dressing for the patient and the wound at each review.
If area reduction is <50% at 4 weeks consider: PROMOGRAN™ Protease Modulating Matrix or PROMOGRAN PRISMA™ Wound Balancing Matrix

Protect/offload: Ensure dressing is compatible with mode of offloading and can be accommodated without bulk or creasing

PLEASE NOTE
This algorithm is based on the WUWHS DFU Position Document* and is a guide only.

The choice of dressings and devices must be based on local protocols and clinical judgement