Wound care management: the podiatrist's perspective

Treating wounds of the diabetic foot provides a significant challenge to the clinician. **Mahomed Abramjee** [NHD Pod (SA)] offers an approach to the identification of susceptible patients and to the prevention and treatment of wounds from the point of view of the podiatrist.

INTRODUCTION

At some time in their career, all primary care and family practice doctors and podiatrists will encounter diabetic patients. The diabetic patient brings with him or her conditions that lead to breakdown of the skin and deeper tissues. Neuropathy, in combination with angiopathy, gives the treating clinician a significant challenge in attempting to heal wounds of the diabetic foot. In addition, there may be neuropathy, which may further delay wound healing.

The neuropathy is perhaps the most dangerous complication of diabetes, as it may reduce pain signals from the foot. Denial should be considered another complication of diabetes, because it is a very real entity that the treating podiatrist must take into account when treating this category of patient.

Even when properly managed, the wounds may not heal as well as expected, and healing is often temporary if not properly maintained. The care of the diabetic is best managed by a team of experts familiar with long term patterns of ulceration and wound healing in the diabetic patient. This article will attempt to provide an orderly approach to the identification of susceptible patients as well as the prevention, and treatment of wounds from the point of view of a podiatrist.

ASSESSMENT

The aetiology of the presenting wound must first be assessed, so that appropriate management may be instituted. Many conditions, other than diabetes lead to chronic ulcers on the feet. These include venous stasis, peripheral arterial disease, neuropathy due to alcoholism, leprosy or trauma. The connective tissue diseases are occasionally responsible.

History

A thorough history and physical examination should *be* performed on every patient. The patients may be given a questionnaire in which they list their history, specific wound history, previous treatments, a list of allergies and current medication (both topical and systemic). A history of smoking, alcohol consumption and dietary habits may be helpful.

Since the patient is directly responsible for self management between visits, some idea of the mental status should be ascertained. If the patient cannot take care of him or herself, then a home care nursing service must be involved to do daily (or more frequent) dressing changes and other care.

Wound history

The specific history aimed at the wound itself is a crucial aspect of the history. The initial incident that allowed the wound to form can be recognised in a wide variety of circumstances. Trauma is an obvious cause in an otherwise healthy person. This can be in the form of a laceration or bruise or a foreign body; occult or otherwise. Previous surgery is another common cause of the chronic wound. While wound dehiscence or failed secondary intention closure is an uncommon complication of surgery it is a common source of the chronic wound.'

Protective devices such as orthoses or splints may have been used. If not used properly they may cause iatrogenic wounds to form in other areas, and the podiatrist should be aware of it. The use of total contact casts or regular casts should be recorded as well. Patient's compliance *can* often be hindered with long term casting, despite its necessity.

Debridements that have been performed may result in altered anatomy, especially if osseous reconstruction or resection was involved in the surgery. Culture results and clinical response to treatment should be documented, with specific inquiry into the most recent antibiotic given, and its duration and effectiveness.