As these patients are chronic wound formers, many times they recur or breakdown in other locations as previously mentioned. An understanding of the pattern of skin breakdown, its aetiology, and recurrence scenario, will assist in creating a treatment plan'.

EXAMINATION

The physical exam should begin with a general overview of the patient. Upon entering the treatment room, one should note the presence of obesity and the level of personal hygiene, which can be signs of their self image and predictors of their compliance. Their current state of ambulation, and dependence on devices or wheelchairs can also be assessed.

A quick mental status examination should be performed. This need not be a psychiatric overview, but their alertness and ability to remember and follow directions should *he well* known. Their motor function and co-ordination must be taken into account, as a component of their gait pattern. Just as motor abnormalities will contribute to the formation of a wound and prevent a wound from healing, deficits in sensorium will delay wound healing". The sensory examination, and vascular assessment, are the core of the examination. Vibratory **sense is the** earliest of senses to *he* lost with a diabetic state. This can be easily assessed with the use of a tuning fork. When struck and held against bony prominences, vibration should be felt by the patient for about twenty seconds. The clinician should start distally, at bony prominences, such as the tips of **the toes,** the apex of hammered digits, prominences of bunion deformities, and head proximally to LisFranc's joint, and *the* malleoli and tibial crest. One should also **test** areas of ulceration, such as a plantar Charcot breakdown.

Proprioceptive and sharp dull discrimination are vital to a wound free foot, and these sensations are invariably lost in **the** diabetic or otherwise neuropathic patient. The test tor proprioception is one of the simplest tests that can be done without instrumentation, yet it is of ten performed incorrectly so that the examiner is not getting a true appreciation oi the patient's true proprioceptive sense. The examiner shot· Id place his or her thumb and forefinger on *the* medial and lateral aspect of the hallux. After taking the digit through a gentle range of motion, the examiner should ask the patient the location of the digit in space, (up or down) while the patient's eyes are closed. This **test** is too often performed without taking care to place tlie examiner's hand properly. If the examiner's finger and thumb are located in a dorsal and plantar fashion, pressure is induced on *the* skin *with* changing forces and direction through the range of motion and this may give misleading results. Sharp/dull discrimination loss will of course allow a patient to step on a pin or nail %, bile thinking it is perhaps just a fold of a sock in his or her shoe. This should be tested either gently, with a safety pin, or with the broken off end of a wooden cotton swab. Extremities should be tested bilaterally at similar levels, as is the case with all of the testing mentioned in this chapter.

Light touch is the primary **sense** that will allow the patient to **sense** and prevent areas of impending breakdown. When lost, ulceration is inevitable. Therefore, gLiantifying the pressure sense in a patient's foot is crucial to the examination.

The examination of the musculoskeletal system is likely **to** yield a great deal of information regarding the patients wound. The examina t should take into account the general muscular status of the extremity. In neuropathic patients, there is often a motor component to the neuropathy which will result in wasting of the int rin-