

70TH ESCVS CONGRESS & 7TH IMAD MEETING

20	23 JUN	E 2022
		ANEURYSMAL PATHOLOGY

DIABETIC FOOT SYNDROME AND NEURO-ISCHEMIC WOUND HEALING

Dr. Víctor Rodríguez Sáenz de Buruaga

Donostia University Hospital Vascular Surgery Diabetic Foot Unit



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CONFLICT OF INTEREST STATEMENT

I have no potential conflicts of interest to report

DIABETIC FOOT

NEUROPATHIC



NEUROISCHEMIC



ISCHEMIC

HOW TO TREAT NEUROISCHEMIC DIABETIC FOOT ULCER TO ACHIEVE HEALING

NEUROISCHEMIC WOUND

DEBRIDEMENT

DRESSING

OFFLOADING

Objective: To promote healing process until wound closure.

DEBRIDEMENT

To remove devitalized tissues, debris and foreign bodies present in the wound.

*Footnote Special Issue Winter 2019. www.d-foot.org

HOW TO PERFORM DEBRIDEMENT?

Sharp/surgical debridement

Fast and effective

Indicated in: Areas of necrosis, slough and callus.

To be done at each dressing.

Must be combined with other methods of debridement.

Recommendation I: Remove slough, necrotic tissue and surrounding callus of a diabetic foot ulcer with sharp debridement in preference to other methods, taking relative contraindications such as pain or severe ischemia into account. (GRADE Strength of recommendation: Strong; Quality of evidence: Low)

IWGDF Guideline on interventions to enhance healing of foot ulcers in persons with diabetes

Part of the 2019 IWGDF Guidelines on the Prevention and Management of Diabetic Foot Disease

GOALS OF DEBRIDEMENT

- REMOVE NECROTIC TISSUE AND PERILESIONAL HYPERKERATOSIS.
- > PRESSURE RELEASE.
- ALLOWS TO EXAMINATE COMPLETELY THE WOUND: REAL DIMENSION AND DEPTH.
- > FACILITATES **DRAINAGE**.
- > STIMULATES HEALING.

CONTROL WOUND EXUDATE

PROMOTION WOUND HEALING

Consider the use of **negative pressure wound therapy** to reduce wound size, in addition to best standard of care

Consider the use of the **sucrose-octasulfate impregnated dressing** as an adjunctive treatment, in addition to best standard of care, in non-infected, neuro-ischaemic diabetic foot ulcers that are difficult to heal

CAUSES OF EXCESS EXUDATE

INFECTION

Antibiotics

DEBRIS

Dedridement and continuous wound cleansing

CHRONIC INFLAMMATION

Balancing the level of metalloproteases

OVERLOADING

We must ensure a correct offloading

SECONDARY ABSORBENT DRESSINGS REDUCTION OF DRESSING CHANGES

PROMOTION WOUND HEALING

Sucrose octasulfate dressing versus control dressing in patients with neuroischaemic diabetic foot ulcers (Explorer): an international, multicentre, double-blind, randomised, controlled trial

Michael Edmonds, José Luis Lázaro-Martínez, Jesus Manuel Alfayate-García, Jacques Martini, Jean-Michel Petit, Gerry Rayman, Ralf Lobmann, Luigi Uccioli, Anne Sauvadet, Serge Bohbot, Jean-Charles Kerihuel, Alberto Piaggesi

THE LANCET Diabetes & Endocrinology

us and challenging wounds associated with high risk of infection and I neurojschaemic if peripheral neuropathy and peripheral artery disease for neurojschaemic ulcers currently exists, and no evidence supports one ne effect of a sucrose octasulfate dressing versus a control dressing on emic diabetic foot ulcers.

nd clinical trial (Explorer) in 43 hospitals with specialised diabetic foot 1 the UK. Eligible participants were inpatients or outpatients aged 18 years suroischaemic diabetic foot ulcer greater than 1 cm² and of grade IC or IIC betic Wound Classification system). We excluded patients with a severe ing the trial and those who had surgical revascularisation in the month d participants (1:1) via a computer-generated randomisation procedure y centre and wound area (1–5 cm² and 5–30 cm²), to treatment with either a control dressing (the same dressing without sucrose octasulfate) for ed the same standard of care for a 2-week screening period before c trial. Dressings were applied by thursing staff (or by instructed relatives sing changes were decided by the investigator on the basis of the clinical sed 2-weeks after randomisation, then monthly until week 20 or occurrence assessed by intention-to-treat, was proportion of patients with wound rith ClinicalTrials.gov, number NCT0717183.

h 31, 2016, we randomly assigned 240 individuals to treatment: 126 to the the control dressing. After 20 weeks, wound closure occurred in te dressing group and 34 patients (30%) in the control dressing group 30; adjusted odds ratio 2-60, 95% C11-43-4-73; p=0-002). In both groups, scions of the target wound: 33 wound infections in 25 (20%) patients of tp and 36 in 32 (28%) patients of 114 in the control dressing group. Minor yere also reported in one (1%) patient in the sucrose octasulfate dressing dressing group. Three (2%) patients assigned to the sucrose octasulfate ntrol dressing died, but none of the deaths were related to treatment, ent to amputation.

Ig significantly improved wound closure of neuroischaemic diabetic foot ks of treatment along with standard care. These findings support the use atment for neuroischaemic diabetic foot ulcers.

OFFLOADING

Total contact cast or nonremovable knee-high walker

Removable knee-high offloading device

Removable ankle-high offloading

Felted foam conventional or standard therapeutic footwear

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Guidelines on offloading foot ulcers in persons with diabetes (IWGDF 2019 update)

Sicco A. Bus¹ | David G. Armstrong² | Catherine Gooday^{3,4} | Gusta¹ Carlo F. Caravaggi^{7,8} | Vijay Viswanathan⁹ | Peter A. Lazzarini^{10,11} on behalf of the International Working Grroup on the Diabetic Foot (IWGDF)

OFFLOADING OBJECTIVES

- > REDUCE PLANTAR PRESSURE.
- > REDUCE SHEAR FORCES.
- > REDISTRIBUTE PLANTAR PRESSURES BY INCREASING SURFACE.
- > OFFLOAD AREAS AT RISK OF ULCERATION.
- > AVOID CHARGE TRANSFER SYNDROME.

Guidelines on diagnosis, prognosis, and management of peripheral artery disease in patients with foot ulcers and diabetes (IWGDF 2019 update)

 Robert J. Hinchliffe¹
 Rachael O. Forsythe²
 Jan Apelqvist³
 Edward J. Boyko⁴

 Robert Fitridge⁵
 Joon Pio Hong⁶
 Konstantinos Katsanos⁷
 Joseph L. Mills⁸

 Sigrid Nikol⁹
 Jim Reekers¹⁰
 Maarit Venermo¹¹
 R. Eugene Zierler¹²
 Nicolaas

 C. Schaper¹³
 on behalf of the International Working Group on the Diabetic Foot (IWGDF)

Always consider **vascular imaging** in patients with a DFU, irrespective of the results of bedside tests, when the ulcer is not healing within 4 to 6 weeks despite good standard of care. (Strong; low)

Always consider **revascularization** in a patient with a DFU and PAD, irrespective of the results of bedside tests, when the ulcer is not healing within 4 to 6 weeks despite optimal management. (Strong; low)

