Northern Kentucky Medical Society

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NKMS Society Rounds

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MANAGEMENT OF DIABETIC FOOT ULCERS

It is estimated that 30.3 million people in the US have diabetes. Presently, 12.2% of all U.S. adults are affected and 25% of all patients will develop a diabetic foot ulcer (DFU). Why is this important? First, DFU's precede 85% of all diabetic lower extremity amputations. Second, the chance of needing a second amputation over the next year is 10-15%. Moreover, a below the knee amputation in a diabetic patient is associated with a 50% five-year mortality rate. Locally, it is estimated that in Kenton, Campbell, and Boone Counties there are approximately 12,000 active DFU's at any given point in time.

Three factors consistently play an important role in the development of DFU's: structural foot abnormalities, sensory neuropathy, and PAD. Because of the high morbidity and mortality associated with DFU's, management needs to be aggressive, multifaceted, and interdisciplinary. 60% of DFU's present with some clinical signs of infection which may include cellulitis, abscess, tenosynovitis, myositis, fasciitis, septic arthritis, osteomyelitis, or a combination. Identifying and treating any infection is the first step. Once controlled, management consists assessing and establishing adequate arterial perfusion, offloading, and local wound care.

Evaluating arterial perfusion is the second step. Revascularization, either endovascular intervention or surgical bypass, increases the likelihood of the DFU healing and decreases the risk of limb loss. Standard of care dictates that all patients with a DFU have noninvasive arterial studies in a vascular lab irrespective of palpable pulses or bedside ABIs.

The third step is offloading. Total contact casting is the gold standard but other modalities used include PEG shoes, removable walking boots, wedge shoes, surgical shoes, leg caddies, and plastizote insoles. Achilles tendon lengthening or surgical corrections of abnormalities are more invasive options. However, these procedures and custom molded AFO braces, orthotics, shoes are more effective in preventing ulcers than treating an active DFU.

The last step is local wound care, typically involving a wound care specialist. This involves maintaining a clean and moist wound environment through local wound dressings, edema control, and debridement. If a DFU does not respond to standard wound care (50% reduction in ulcer size by 4 weeks) then advanced wound care therapies are indicated. This includes use of collagen matrix xenografts, bioengineered cellular and tissue-based grafts, skin grafts (autologous, cadaveric), wound VAC, and hyperbaric oxygen therapy (HBOT). Usually a combination of therapies is needed to bring about complete healing of a DFU. The following case is illustrative:

A 58-year-old white male smoker with type 2 diabetes mellitus, hypertension, hyperlipidemia, peripheral neuropathy, and nephrolithiasis presented to the ED with right heel, ankle, and calf pain and a nonhealing ulcer over the right lateral heel. For the past 4 weeks the ulcer was not healing despite daily application of Polysporin ointment with a dry sterile dressing.

On presentation, the patient's right heel, proximal foot and ankle were cellulitic and the right plantar lateral heel was fluctuant.

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MANAGEMENT OF DIABETIC FOOT ULCERS

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On admission his white blood cell count was 11,000, blood sugar was 389, and hemoglobin A1c was 7.3. X-ray of the right foot and heel were negative. MRI showed calcaneal osteomyelitis with an adjacent 10 x 5 mm subcutaneous abscess and soft tissue changes consistent with cellulitis. Arterial Doppler exam revealed normal ABIs bilaterally, and normal toe pressure bilaterally. Patient initially underwent a bedside I&D of this abscess by podiatry which grew MSSA, followed by a more formal open I&D with ostectomy of the right calcaneus 4 days later. Pathology was consistent with acute osteomyelitis. He was treated by infectious diseases with IV Ancef for a full 6 week course. Post hospital discharge, patient was followed at the St. Elizabeth Wound Care Center where his ulcer initially measured 5 x 1.5 x 1.4 cm and extended down to the periosteum. Initially treated with a wound VAC and then was referred for HBOT therapy for his Wagner 3 DFU. For 2 months, he completed a total of 40 daily HBOT treatments and his wound depth decreased from 1.4 cm to 0.4 cm. The wound VAC was discontinued and he was treated with every other day Prisma applications (collagen matrix with cellulose and silver). Then, his ulcer healing began to stall, prompting a 5 week series of Grafix, a cryopreserved placental membrane graft, which were applied weekly with compression wraps. The ulcer began showing progressive healing with a decrease in wound dimensions to 1.6 x 0.6 x 0.2 cm. This was followed by an Xpanse skin graft (a minced split thickness skin autograft) followed by a cellutome epidermal harvest graft 4 weeks later, and ultimately, weekly applications of Adaptic with a dry sterile dressing. Four weeks after this, the patient's DFU had finally healed.

The St. Elizabeth Wound Care Center is located in Covington, Fort Thomas, and Grant County and is comprised of 11 physicians and one nurse practitioner with multiple subspecialties represented. We look forward to partnering with you in the management of your patients with wounds.

Roger Teller, MD

Upcoming Events

April 17, NKMS Executive Board Meeting

May 31, Trustee Dinner

July 17, NKMS Executive Board Meeting

August 24-26, KMA Annual Meeting

September 18, NKMS Executive Board Meeting

October 4, Meet Your Legislators Dinner

November 13, NKMS Executive Board Meeting

December 14, Holiday Party

President's Article-Words Matter

In early February your Northern Kentucky Medical Society sponsored a winter dinner forum with the Northern Kentucky Independent District Health Department about "The Power of Partnerships- Responding to the Opioid Crisis." We shared initiatives and proposed strategies to help curb this national crisis as it effects Northern Kentuckians. I included in the information distributed that evening an article from Marshall University titled "Words Matter: Using the language of recovery to reduce stigma." Stigma remains one of the biggest barriers to addiction treatment faced by our patients. The terminology we use in our medical profession often contributes to that stigma. Research shows that the language we use to describe this disease can either perpetuate or overcome the stereotypes, prejudice and lack of empathy that keep people from getting the treatment they desperately need. That being said, I have found it very difficult to change the well-established medical language I use daily.

My ninety-two year old father was recently hospitalized with congestive heart failure. He is back home now and doing well, living with my mother in an assisted living facility in Cincinnati. I was reminded why words matter so much during his hospital stay. As the medical professional in my family, I am often called upon to give my 'opinion.' I kept trying to reassure my sister and brother with comments like "he has heart failure, but doing much better. He's only on two liters and diuresing well." They could not get passed the term 'failure' in 'congestive heart failure'. They both thought it was the end. To them, something that had failed was in a state of not functioning. My father has always had a good heart (and normal ejection fraction by the way). It seemed unkind to continue to use the term congestive heart failure.

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President's Article-Words Matter

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I changed my language to "his doctors are managing his congestive heart disease." I wonder how many other families I unknowingly caused consternation over the years by calling it heart failure.

"Debates over language often seem absurd or trivial. However, they make a difference in how issues are framed and therefore what solutions are proposed. Frame addiction as "substance abuse" and it is easy to see why it should be called a crime, but call it "substance use disorder" and it sounds like something to be treated medically. If we want to make progress in ending stigma, we should think hard about the words we use." (Szalavitz, 2014)

In substance use disorders, we can use our language to accomplish four goals:

1. Use language that respects the worth and dignity of all;
2. Use language that focuses on the medical nature of substance use disorders and treatments;
3. Use language that promotes the recovery process; and
4. Avoid perpetuating negative stereotypes and biases through the use of slang and idioms.

I'm trying to eliminate terms like junkie, addict, user, abuser and alcoholic from my jargon. I'm going to use people-first language instead: individuals struggling with the disease of addiction; people not yet in recovery; a PERSON with a substance use disorder. Here are some other ways we can de-stigmatize our language:

Current	De-stigmatizing	Reason
Drug-addicted baby	Infant with pre-natal exposure	person -centered
Non-compliant	Struggling with ambivalence Pre-contemplation stage	not blaming; offers change, not labeling
Substance abuse	substance use disorder	medical diagnosis
Drug of choice	Drug used	often not a choice
Treatment is the goal	Treatment is an opportunity	reduces judgment
Clean/sober	Drug/medication/alcohol free	stigma-free
Relapse	Recurrence/return to use	baggage free
Abstinence/sobriety	Individual in recovery	precludes MAT
Replacement drugs	Medication Assisted Treatment	needed for some
Rock bottom	Ready for change	Waiting for a crisis is dangerous

Words do matter. It is going to be very difficult for me to change. If we all work on our language, then it will be easier for all of us to change. Hearing people-first language in the doctor's lounge and throughout the hospital will make it easier for me to adapt. It will also be easier for new learners to use de-stigmatizing medical language if they hear it from all of us. Hopefully our effort to improve the words we use will open doors and help us reach more Northern Kentuckians in need of change.

Give me a call or send me a text. Let me know how the NKMS can best serve you.

Mark A. Boyd, MD, FAAFP

President

Northern Kentucky Medical Society

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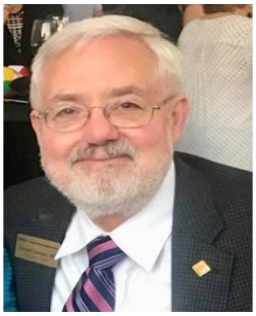
NKMS Alliance Report

Hopefully spring weather is right around the corner. NKMSA members will be joining the KMAA annual meeting in the Grand Victorian Inn, Park City, on April 17-19, 2018. The KMAA will be celebrating its **95th** anniversary! We will be hearing greetings from our own, Kim Moser, 2018 AMAA President, and Dr. Don Swikert, 2018 SMAA President-Elect. What a fun time!



NKMSA members will be traveling to the AMAA Annual meeting in Chicago to celebrate a very successful year of service by Kim Moser as President of the AMAA 2017-18. Everyone is invited to attend. Registration is available at amaalliance.org. Hope to see some of you there.

Nancy Swikert, MD
President, NKMSA