**FAST-TRACK PATHWAY FOR DIABETIC FOOT ULCERATION**

**FIRST ASSESSMENT**

**CO-MORBIDITIES**
- Heart failure class
- End stage renal failure
- Depression

**HOLISTIC APPROACH**
- Medical history
- Clinical exam.
- Biology

**ASSESSMENT OF DIABETIC FOOT LESION AND LOWER LIMB**

**NON COMPLICATED DFU**
- Absence of necrosis/gangrene
- Absence of bone, muscle and/or tendon exposure
- Normal pulses
- Absence of signs of infection

**COMPLICATED DFU**
- Necrosis
- Bone, muscle and/or tendon exposure
- Absence of abnormal pulses
- Sign of infection

**SEVERE COMPLICATED DFU**
- Gangrene / Pneumonia / Fever or other signs of sepsis

**SEVERE COMPLICATED DFU**
- DM Patient with lesion with dialysis or heart failure

**STANDARD OF CARE**
- Follow up with recheck

**REFERRAL TO CENTER OF REFERENCE**
- In cooperation with first line
- Further follow up

**URGENT HOSPITALISATION IN 24H TO SPECIALISED DF CLINIC**
- Decrease mortality + Limb salvage

**PRINCIPLES OF STANDARD OF CARE**

**Offloading:** Reduction of extrinsic and/or intrinsic biomechanical stress/plantar pressure is essential for ulcer protection and healing. The use of non-removable knee-high offloading devices, total contact casts (TCC), removable walkers or specific footwear should be used tailored to individual need and according to local available resources. Patients should be educated to minimise standing and walking. Regular follow-up should be undertaken to ensure clinical effectiveness and compliance.

**Restoration of foot perfusion:** In patients with peripheral arterial disease (ankle pressure <50mm Hg, ABI <0.5, toe pressure <30mm Hg or Top22 >25 mmHg), revascularisation should be considered. When an ulcer does not show signs of healing within 4 weeks, despite optimal management, further vascular assessment and revascularisation should be considered (even if the tests above fall within acceptable/norma range).

**Treatment of infection:** When there are any clinical signs of infection, empiric and broad-spectrum antibiotic therapy should be administered after obtaining microbiological samples (ideally deep tissue), followed by adjustments according to clinical response and microbiological results. Removal of any necrotic or non-viable tissue following comprehensive assessment of infection severity is required.

**Metabolic control/Holistic management:** Metabolic approach requires optimisation of glycaemic control (if necessary with insulin), the treatment of malnutrition and oedema if present. Optimal management of relevant co-morbidities is mandatory.

**Local wound care:** Frequent ulcer inspection/assessment, debridement and redressings should be undertaken. Dressing selection is based upon ulcer findings (characteristics of wound bed, exudation, size, depth, local pain). In case of neuro-ischemic ulcers, dressings with TLC-NOSP (Lipid-Colloid Technology with Nano-OligoSaccharide Factor) should be considered.