

Inpatient Diabetic Foot /Leg Ulcer/Foot Infection: Assessment, Investigation and referral pathway

Patient admitted with Diabetes and foot or leg ulcer

Assess the patient and inspect feet and legs with dressings removed

Examine and record:

Presence / extent of ulceration

Presence / extent of infection / cellulitis (see appendix below)

Presence / extent of deformity for Charcot foot

Examine pulses – are there palpable pulses?

Examine for neuropathy

Assess Glycaemic control and ketones in blood / urine

Investigations:

X ray foot/leg

Soft tissue sample from wound base / aspirate / swab

Measure ABPI. If there are no palpable pulses request an urgent arterial duplex

Blood tests as indicated: FBC, CRP, U&E, HbA1c, Blood cultures

Record regular vital observations (temp, BP, pulse)

Treatment Priorities

Treat infection as per microbiology guidance

Treatment of infection and ischaemia (revascularisation or amputation)

Glycaemic control (prioritise if dysglycaemia severe or ketotic)

Non-weight bearing on affected limb until assessed by foot care team

Off loading - foot care team to refer to orthotist as required.

**Refer to foot team (Podiatry/Vascular Surgery/Diabetes) for review
within 24 hours-do not delay**

**If evidence of ischaemia and / or infection refer to Vascular surgery
- Contact the on call Vascular Consultant directly via switchboard
for review the same day**

Diabetes Consultant: Bleep 85694 (0900-1700 Monday to Friday) or phone the short stay ward if no response

Diabetes nurse inpatient team - bleep 0989

Podiatry: 53032/53047 for follow up/foot care guidance

Tissue Viability Team for dressings advice

Admission (see appendix)

If admission is indicated, admit to medical ward if not suitable for vascular surgery ward (the foot team should decide which is the most appropriate). Patients should stay on admitting unit until this achieved.

An exception to this can be when the renal unit require the patient on their ward (referrals to foot team should still go ahead as above).

Appendix 1.

Admission criteria for diabetic foot ulceration

Assess infection using: Infectious Diseases Society of America and International Working Group on the Diabetic Foot Classifications of Diabetic Foot Infection. Lipsky et al Clinical Infectious Diseases 2012;54(12):132–173.

Clinical Manifestation of Infection	PEDIS Grade	IDSA Infection Severity
No symptoms or signs of infection	1	Uninfected
Infection present, as defined by the presence of at least 2 of the following items:		
<ul style="list-style-type: none"> Local swelling or induration Erythema Local tenderness or pain Local warmth Purulent discharge (thick, opaque to white or sanguineous secretion) 		
Local infection involving only the skin and the subcutaneous tissue (without involvement of deeper tissues and without systemic signs as described below). If erythema, must be >0.5 cm to ≤2 cm around the ulcer. Exclude other causes of an inflammatory response of the skin (eg, trauma, gout, acute Charcot neuro-osteoarthropathy, fracture, thrombosis, venous stasis).	2	Mild
Local infection (as described above) with erythema > 2 cm, or involving structures deeper than skin and subcutaneous tissues (eg, abscess, osteomyelitis, septic arthritis, fasciitis), and No systemic inflammatory response signs (as described below)	3	Moderate
Local infection (as described above) with the signs of SIRS, as manifested by ≥2 of the following: <ul style="list-style-type: none"> Temperature >38°C or <36°C Heart rate >90 beats/min Respiratory rate >20 breaths/min or PaCO₂ <32 mm Hg White blood cell count >12 000 or <4000 cells/μL or ≥10% immature (band) forms 	4	Severe ^a

Abbreviations: IDSA, Infectious Diseases Society of America; PaCO₂, partial pressure of arterial carbon dioxide; PEDIS, perfusion, extent/size, depth/tissue loss, infection, and sensation; SIRS, systemic inflammatory response syndrome.

^a Ischemia may increase the severity of any infection, and the presence of critical ischemia often makes the infection severe. Systemic infection may sometimes manifest with other clinical findings, such as hypotension, confusion, vomiting, or evidence of metabolic disturbances, such as acidosis, severe hyperglycemia, and new-onset azotemia [29, 43, 44].

Admit:

1. All patients with a **severe** infection,
2. Selected patients with a **moderate** infection with complicating features (eg, severe peripheral arterial disease [PAD] or lack of home support), or who require urgent surgical debridement for e.g. deep collections or are unable to comply with the required outpatient treatment regimen
3. Patients with **critical limb ischaemia**
4. Patients who do not meet any of these criteria, but are failing to improve with outpatient therapy, may also need to be hospitalized
5. Patients whose diabetes control has deteriorated to the point that it is now an acute problem in it's own right

Once admitted:

Prior to being discharged, a patient with a DFU should be clinically stable; have had any urgently needed surgery performed; have achieved acceptable glycemic control; be able to manage (on his/her own or with help) at the designated discharge location; and have a well defined plan that includes an appropriate antibiotic regimen to which he/she will adhere, an off-loading scheme (if needed), specific wound care instructions, and appropriate outpatient follow-up

**Guidance Title: Inpatient Diabetic Foot, Leg Ulcer, Foot Infection:
Assessment, Investigation and Referral pathway**

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