IQED-FOOT INFORMATION MEETING AUDIT 8

Barriers and workarounds

17 June 2025, Brussels

INTRO

Margot Buyle PhD and Dr Michel Vandenbroucke

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Welcome

18h00 | Registration and walking dinner

19h30 – 22h15 | Three sessions are organised, each with a presentation and a discussion. Each session will last a maximum of 45 minutes, and will be presented by members of the IQED-Foot Expert Group.

- Session 1: *Prof. Dr. Caren Randon (UZ Ghent), Dr. Sabrina Houthoofd (UZ Leuven), Prof. Dr. Dimitri Aerden (UZ Brussels)* : **‘Decision making in the PEDIS-3 foot population’**
- Session 2: *Prof. Dr. Frank Nobels (AZORG Aalst), Dr. Patrick Lauwers (UZ Antwerp), Prof. Dr. Giovanni Matricali (UZ Leuven)* : **‘The practice of offloading: the good, the bad and the ugly’**
- Session 3: *Cédric Lannoo (UZ Ghent), Sabine De Bruyne (AZ Sint-Lucas Ghent), Prof. Dr. Eveline Dirinck (UZ Antwerp)* : **'The podiatrist in the diabetic foot clinic : role, challenges and future'**

22h30 | End

Accreditation ‘Ethics and economics’ is available.
All presentations will be given in English.

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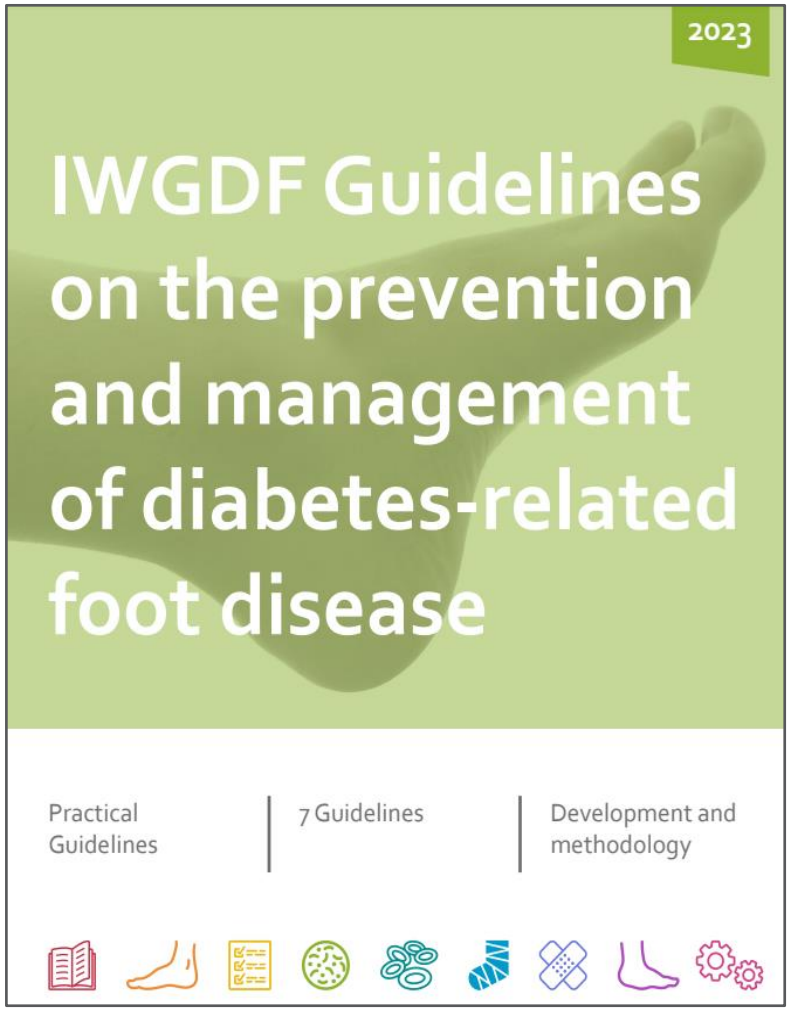
Diabetic Foot: a hot topic in the literature

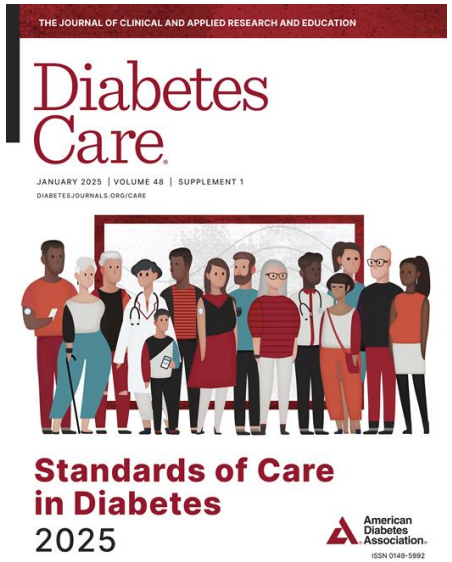
- Pubmed : ‘Diabetic Foot’ revealed 971 results published in the last 12 months
- 25 meta-analyses, mostly about treatment options
- 177 review articles
- Variety of topics : AI and digital tools, societal burden, diagnostic tools, treatment options, outcome studies …
- Largest and prestigious journals (Lancet, JAMA, Diabetes Care, BMJ, …)
- Life long eminent scientists continue publishing
- JAMA 2023 Jul 3;330(1):62-75. **Diabetic Foot Ulcers: A Review**

David G Armstrong [1], Tze-Woei Tan [1], Andrew J M Boulton [2], Sicco A Bus [3]

Conclusions and relevance: Diabetic foot ulcers affect approximately 18.6 million people worldwide each year and are associated with increased rates of amputation and death. Surgical debridement, reducing pressure from weight bearing, treating lower extremity ischemia and foot infection, and early referral for multidisciplinary care are first-line therapies for diabetic foot ulcers.

Diabetic Foot: Conferences and Guidelines





Retinopathy, Neuropathy, and Foot Care: Standards of Care in Diabetes—2025

American Diabetes Association Professional Practice Committee

Diabetes Care 2025;48(Supplement_1):S252–S265

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Retinopathy, Neuropathy, and Foot Care: Standards of Care in Diabetes – 2025 – page S258-259

Recommendations

12.23 Perform a comprehensive foot evaluation at least annually to identify risk factors for ulcers and amputations. A

12.24 The examination should include inspection of the skin, assessment of foot deformities, neurological assessment (10-g monofilament testing or Ipswich touch test with at least one additional assessment: pinprick, temperature, or vibration), and vascular assessment, including pulses in the legs and feet. B

12.25 Individuals with evidence of sensory loss or prior ulceration or amputation should have their feet inspected at every visit. A

12.26 Obtain a prior history of ulceration, amputation, Charcot foot, angioplasty or vascular surgery, cigarette smoking, retinopathy, and renal disease and assess current symptoms of neuropathy (pain, burning, numbness) and vascular disease (leg fatigue, claudication). B

12.27 Initial screening for peripheral arterial disease (PAD) should include assessment of lower-extremity pulses, capillary refill time, rubor on dependency, pallor on elevation, and venous filling time. Individuals with a history of leg fatigue, claudication, and rest pain relieved with dependency or decreased or absent pedal pulses should be referred for ankle-brachial index with toe pressures and for further vascular assessment as appropriate. B

12.28 An interprofessional approach facilitated by a podiatrist in conjunction with other appropriate team members is recommended for individuals with foot ulcers and high-risk feet (e.g., those on dialysis, those with Charcot foot, those with a history of prior ulcers or amputation, and those with PAD). B

12.29 Refer individuals who smoke and have a history of prior lower-extremity complications, loss of protective sensation, structural abnormalities, or PAD to foot care specialists for ongoing preventive care and lifelong surveillance. B These individuals should also be provided with information on the importance of smoke cessation and referred for counseling on smoke cessation. A

12.30 Provide general preventive foot self-care education to all people with diabetes, including those with loss of protective sensation, on appropriate ways to examine their feet (palpation or visual inspection with an unbreakable mirror) for daily surveillance of early foot problems. B

12.31 The use of specialized therapeutic footwear is recommended for people with diabetes at high risk for ulceration, including those with loss of protective sensation, foot deformities, ulcers, callous formation, poor peripheral circulation, or history of amputation. B

12.32 For chronic diabetic foot ulcers that have failed to heal with optimal standard care alone, adjunctive treatment with randomized controlled trial–proven advanced agents should be considered. Considerations might include negative-pressure wound therapy, placental membranes, bioengineered skin substitutes, several acellular matrices, autologous fibrin and leukocyte platelet patches, and topical oxygen therapy. A

Retinopathy, Neuropathy, and Foot Care: Standards of Care in Diabetes – 2025 – page S258-259

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For recalcitrant deformities or for recurrent ulcerations not amenable to conservative footwear therapy alone, appropriate surgical reconstruction by an experienced diabetic foot surgeon should be considered.

References: Frykberg, Wukich et al, Board of the association of diabetic foot surgeons, surgery for the diabetic foot: a key component of care. Diabetes Metab Res Rev 2020;36 (suppl 1): e3251

Barrier Survey – Results (1/3)

Identification of the most common barriers in diabetic foot clinics in Belgium

OFFLOADING

	Reasons higher rates	Reasons lower rates
Healthcare provider factors	• Strong offloading policy • Patient education • Expertise	• Prevention policy • Limited trained personnel • Encoding problems
Patient factors	• Compliance • Awareness	• Refusal • Patient characteristics
Healthcare system factors	• Intensive multidisciplinary collaboration • Easier access to resources	• Low collaboration • Reimbursement policy

Examples from practice	*Optimal pursuit of offloading Expertise in offloading*	*Prevention policy leading to less severe wounds*
	Commit to patient awareness	*Shortage of staff*
	Presence orthopaedic experts	*Bedridden, palliative patients*

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Barrier Survey – Results (2/3)

Identification of the most common barriers in diabetic foot clinics in Belgium

REVASCULARISATION

	Reasons higher rates	Reasons lower rates
Healthcare provider factors	• Strong revascularisation policy • Expertise	• Conservative approach • Limited trained personnel • Stricter wound selection
Patient factors	• Treating patients with critical limb ischemia	• Patient characteristics • Favorable wound evolution
Healthcare system factors	• Intensive multidisciplinary collaboration • Adequate resources	• Low collaboration

Examples from practice	*Advise and experience from vascular surgeons*	*Shortage of vascular surgeons or radiologists*
	Explain to patients importance	*Non-surgical policy*
	Close cooperation vascular surgery	*Fragile, severely ill patients*

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Barrier Survey – Results (3/3)

Identification of the most common barriers in diabetic foot clinics in Belgium

SECONDARY PREVENTION

	Reasons higher rates	Reasons lower rates
Healthcare provider factors	• Strong secondary prevention policy • Patient education	• Prevention policy • Limited trained personnel
Patient factors		• Refusal • Patient characteristics
Healthcare system factors	• Intensive multidisciplinary collaboration	• Low collaboration • Reimbursement policy • Prescription policy

Examples from practice	*Provision of orthopaedic insoles/shoes*	*Diabetologists cannot prescribe orthopaedic insoles/shoes*
	Orthopaedic shoes always advised	*Reimbursement policy*
	Presence orthopaedic experts	*Bedridden, palliative patients*

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Barrier Survey – Conclusions

Identification of the most common barriers in diabetic foot clinics in Belgium

Reasons General Higher Rates

Reasons General Lower Rates

→ Next steps?

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Session 1. Decision making in the PEDIS-3 foot population

In this session we examine trend changes in the role of (non)-invasive testing for PAD and arterial imaging. We explore revascularisation rates, modalities (endovascular and open) as well as BTK targeting, with a particular interest in the PEDIS-3 population. We offer a hypothesis for the excessive variability among centers in regard to BTK revascularisation.

Organized by: Prof. Dr. Caren Randon (vascular surgeon, UZ Ghent), Dr. Sabrina Houthoofd (vascular surgeon, UZ Leuven), Prof. Dr. Dimitri Aerden (vascular surgeon, UZ Brussels)

Session 2. The practice of offloading: the good, the bad and the ugly

This session will discuss the practical aspects of offloading, based on case studies addressing the discrepancies between guidelines and real-world practices.

Organized by: Prof. Dr. Frank Nobels (diabetologist, AZORG Aalst), Dr. Patrick Lauwers (vascular surgeon, UZ Antwerp), Prof. Dr. Giovanni Matricali (orthopaedic surgeon, UZ Leuven)

Session 3. The podiatrist in the diabetic foot clinic: role, challenges and futures

During this session, several questions will be addressed regarding podiatric care: How is the podiatrist's role fulfilled within diabetic foot clinics? Why is it, that some centres manage to fully deploy the podiatrist in care? What barriers stand in the way of wider deployment? Together, we explore difficulties and opportunities.

Organized by: Cédric Lannoo (podiatrist, UZ Ghent), Sabine De Bruyne (podiatrist, AZ Sint-Lucas Ghent), Prof. Dr. Eveline Dirinck (diabetologist, UZ Antwerp)

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Please download and install the Slido app on all computers you use

Please select 1 option.

When is IQED-Foot registration MOST OFTEN performed in your MDFC?

***MDFC = Multidisciplinary Diabetic Foot Clinic**

ⓘ Start presenting to display the poll results on this slide.

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Please select all that apply.

Who performs IQED-Foot registration in your MDFC?

ⓘ Start presenting to display the poll results on this slide.

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Please select 1 option.

How is INITIAL IQED-Foot registration performed in your MDFC?

ⓘ Start presenting to display the poll results on this slide.

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Please download and install the Slido app on all computers you use

Please select all that apply.

Which member(s) of your MDFC contribute actively and consistently to the report on the patients visit in his/her medical record?

ⓘ Start presenting to display the poll results on this slide.

Please select all that apply.

How often is a full report of the patient's visits at the MDFC created in the medical record (and sent to external parties such as the GP)?

DECISION MAKING IN THE PEDIS-3 FOOT POPULATION

Prof Dr Caren Randon (vascular surgeon, UZ Ghent), Dr Sabrina Houthoofd (vascular surgeon, UZ Leuven), Prof Dr Dimitri Aerden (vascular surgeon, UZ Brussels)

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Diagnosis PAD & CLI in DF

Clinical	Testing	Imaging (diagnosis + revasc. prep)
Peripheral pulsations (tibial arteries) IQED-foot AUDIT 8	Doppler waveform (no signal, monophasic) IQED-foot AUDIT 6-8	CT-angio
Wound characteristics (distal, multiple, (mummified) necrosis, no bleeding during debridement, <>venous/neuropathic)	ABI (unreliable, falsely elevated) IQED-foot	MR-angio (availability)
Dynamic Testing (Buerger-test/Capillary Refill)	TBI (availability, narrow range) IQED-foot	Other (DSA)
Antecedents: coronary, carotid, 'known' atherosclerosis	TcpO2 (diagnostic <> stump healing?) IQED-foot	US (BTK?) IQED-foot
Indirect: X-ray foot shows mediacalcinosis, ATCD		

IQED-foot = "angiography"

IQED-Foot: PAD assessment process: only partially registered

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Non-invasive testing (1/2)

new to Audit 8: peripheral pulses
introduced to Audit 6: doppler
objective = diagnosis of clinical PAD/CLI + indication for imaging / revascularisation

3.4.4.5.3. Resultaten

Tabel 25: Gebruik van niet-invasieve diagnostische tests bij patiënten met een diabetisch voetulcus, audit 3-8, algemene percentages

	Audit 3 (N=1.583)	Audit 4 (N=1.747)	Audit 5 (N=1.857)	Audit 6 (N=1.771)	Audit 7 (N=1.579)	Audit 8 (N=1.977)	Trend
Klinisch onderzoek naar voetpulsaties						1.671 (83,9)	→ good
Meting van enkel-armindex (ABI)	349 (21,6)	259 (14,6)^{cccggg}	347 (17,1)^{cc}	225 (12,4)^{ccceee}	173 (10,3)^{ccceee}	257 (12,9)^{cccee}	---
Teendruk	11 (0,7)	36 (2,1)	31 (1,5)	41 (2,3)^{c}	26 (1,4)	46 (2,6)	infrequent (reliability issue? accessibility?)
$TcPO_2$-meting	47 (2,9)	55 (2,9)	79 (3,3)	64 (3,6)	34 (2,0)	72 (3,4)	
Minstens één van deze 3 metingen	373 (23,1)	291 (16,5)^{cccggg}	379 (18,8)^{c}	267 (14,8)^{ccce}	189 (11,2)^{ccceee}	292 (14,6)^{cccddd}	---
Arterieel Doppleronderzoek	-	-	-	456 (26,4)	508 (30,9)	581 (29,2)	
Geen niet-invasieve diagnostische tests	1.210 (76,9)	1.456 (83,5)^{cccggg}	1.479 (81,2)^{cfff}	1.176 (66,2)^{cccddd}	1.008 (65,5)^{ccceee}	240 (12,7)^{cccddd}	→ encouraging

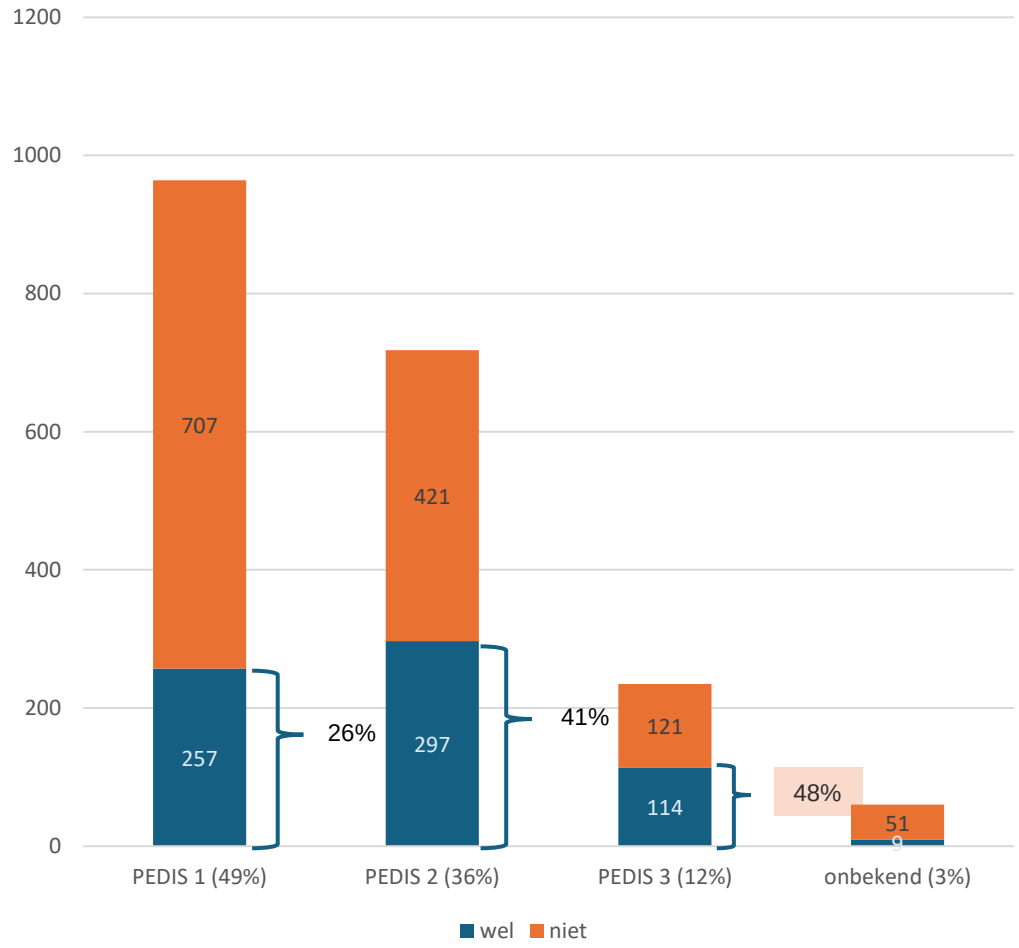
Raadpleeg paragraaf 3.1.1 op p. 17 voor instructies over hoe deze tabel te lezen.

Non-invasive testing (2/2)

"No vascular work up" = quality failure?

- prior or established healing (wait & see)
- revasc. no option or patient refusal
- known or obvious PAD: direct to imaging
- patient inclusion, delayed vascular workup

Non-invasive PAD testing AUDIT 8,
according to PEDIS classification



Imaging

Tabel 27: Gebruik van vasculaire beeldvorming bij patiënten met een diabetisch voetulcus, audits 3-8

	Audit 3 (N=1.583)	Audit 4 (N=1.747)	Audit 5 (N=1.857)	Audit 6 (N=1.771)	Audit 7 (N=1.579)	Audit 8 (N=1.977)	Trend
Algemene percentages							
Arterieel duplexonderzoek	602 (37,5)	926 (53,4)[cc]	1.022 (55,0)[cc]	701 (38,7)[e]	519 (31,8)[ddeee]	741 (37,9)[dee]	
Angiografie	531 (33,5)	559 (32,3)	619 (33,5)	590 (33,2)	552 (33,4)	691 (36,0)	
Rekening houdend met combinaties							
Alleen arterieel duplexonderzoek	376 (23,2)[d]	600 (34,3)	573 (30,8)[f]	351 (19,3)[dd]	254 (15,5)[dddeee]	381 (19,3)[ddee]	--
Alleen angiografie	305 (19,1)[e]	233 (13,3)[e]	170 (9,2)	240 (13,8)[e]	287 (17,2)[ee]	331 (17,4)[e]	
Arterieel duplexonderzoek + angiografie	226 (14,3)[deee]	326 (19,1)[e]	449 (24,2)	350 (19,4)	265 (16,2)[e]	360 (18,6)	
Eender welke vasculaire beeldvorming	907 (56,7)	1.159 (66,7)[ccff]	1.192 (64,2)[f]	941 (52,5)	806 (48,9)[ddee]	1.072 (55,3)[fe]	-
Geen vasculaire beeldvorming	676 (43,3)	588 (33,3)[ccff]	665 (35,8)[fgg]	830 (47,5)	773 (51,1)[dd]	905 (44,7)[de]	+

Raadpleeg paragraaf 3.1.1 op p. 17 voor instructies over hoe deze tabel te lezen.

→ acceptable: no suspicion of clinical PAD (neuropathy, venous, dermato, nail)

Revascularisation 1/2

Tabel 29: Revascularisatiepercentages bij patiënten met een diabetisch voetulcus, algemeen en gestratificeerd volgens PEDIS-perfusiegraad en voorgeschiedenis, in audits 2-8

	Audit 2 (N=985)	Audit 3 (N=1.583)	Audit 4 (N=1.747)	Audit 5 (N=1.857)	Audit 6 (N=1.771)	Audit 7 (N=1.579)	Audit 8 (N=1.977)	Trend
Algemeen percentage	248 (25,0)	401 (25,6)	457 (26,5)	454 (24,5)	419 (23,6)	438 (26,1)	496 (25,5)	
PEDIS-perfusiegraad								
PEDIS-perfusiegraad 1	12/375 (3,2)	27/662 (4,2)	37/756 (5,1)	44/850 (5,3)	27/764 (3,6)	42/700 (6,8)	62/964 (6,5)[bf]	++
PEDIS-perfusiegraad 2	133/437 (30,0)***	219/685 (32,4)***	263/737 (35,8)***	260/755 (34,8)***	225/683 (32,7)***	248/646 (36,7)***	256/718 (36,0) ***	
PEDIS-perfusiegraad 3	99/150 (66,4)***	148/207 (71,6)***	147/219 (67,8)***	141/221 (63,9)***	164/240 (68,2)***	143/203 (67,0)***	163/235 (69,7) ***	
PEDIS-perfusiegraad onbekend	4/23 (17,1)	7/29 (24,8)	10/35 (27,9)	9/31 (29,2)	3/84 (3,5)	5/30 (12,8)	15/60 (24,9)	
Voorgeschiedenis van revascularisatie								
Nee	125/653 (18,9)	200/1.086 (18,3)	181/1.208 (15,1)	181/1.184 (15,4)	154/1.121 (13,9)	168/1.008 (15,6)	192/1.282 (15,2)	
Ja	123/285 (43,1)$$$	201/483 (42,5)$$$	276/526 (53,0)$$$	273/613 (44,6)$$$	265/575 (45,7)$$$	270/510 (51,8)$$$	304/639 (48,3)$$$	
Geen revascularisatie	737 (75,0)	1.182 (74,4)	1.290 (73,5)	1.403 (75,5)	1.352 (76,4)	1.141 (73,9)	1.481 (74,5)	

Raadpleeg paragraaf 3.1.1 op p. 17 voor instructies over hoe deze tabel te lezen.
*,**,*** p < 0,05, p < 0,01, p < 0,001 vs. PEDIS-perfusiegraad 1.
$,$$,$$$ p < 0,05, p < 0,01, p < 0,001 vs. geen voorgeschiedenis van revascularisatie.

PERFUSION (PERFUSIE)	
Graad 1	geen symptomen of tekenen van perifeer arterieel vaatlijden (PAV)
Graad 2	symptomen of tekenen van PAV, maar niet van kritische lidmaatischemie
Graad 3	kritische lidmaatischemie
EXTENT (OMVANG)	
	wondgrootte gemeten in cm^2, na debridement
DEPTH (DIEPTE)	
Graad 1	oppervlakkig ulcus beperkt tot de dermis.
Graad 2	diepe ulcus, dat penetreert door de dermis tot de subcutane structuren zoals fascia, spier of pees
Graad 3	alle onderliggende lagen van de voet zijn betrokken, inclusief bot en/of gewricht (blootliggend bot, ulcus doordringend tot op het bot)
INFECTION (INFECTIE)	
Graad 1	geen symptomen of tekenen van infectie
Graad 2	infectie van de huid en het subcutane weefsel
Graad 3	erytheem groter dan 2 cm of infectie dieper dan huid of subcutis doch zonder systemische inflammatoire symptomen
Graad 4	systemische symptomen van infectie
SENSATION (GEVOEL)	
Graad 1	geen verlies van beschermend gevoel
Graad 2	verlies van beschermend gevoel

Tabel 4.3 : De pijlers van de PEDIS-classificatie

¼ pt (= new chronic wound) gets revascularisation
±90% endovascular (<>hybrid/open)
±50% BTK targeted

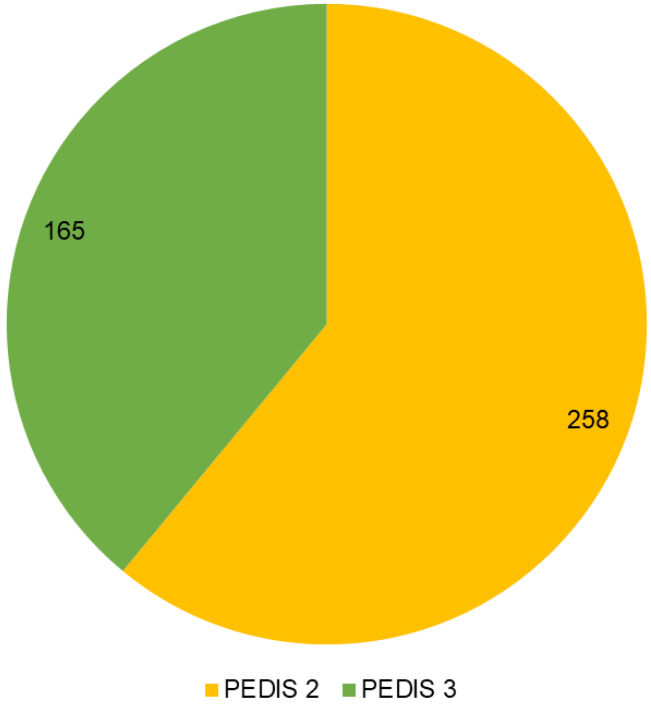
Tabel 30: Revascularisatietype bij patiënten met een diabetisch voetulcus, audits 3-8

	Audit 3 (N=401)	Audit 4 (N=457)	Audit 5 (N=454)	Audit 6 (N=419)	Audit 7 (N=438)	Audit 8 (N=1.977)	Trend
Revascularisatietype, bekend	350 (86,8)	376 (81,7)	454 (100,0)	419 (100,0)	438 (100,0)	496 (100,0)	+++
Endovasculair	311 (89,1)	335 (89,0)	402 (89,0)	359 (85,6)	401 (91,7)[f]	457 (92,4)[f]	
Chirurgisch	53 (14,8)	60 (15,9)	94 (20,2)	85 (20,4)	66 (15,7)	78 (15,3)	

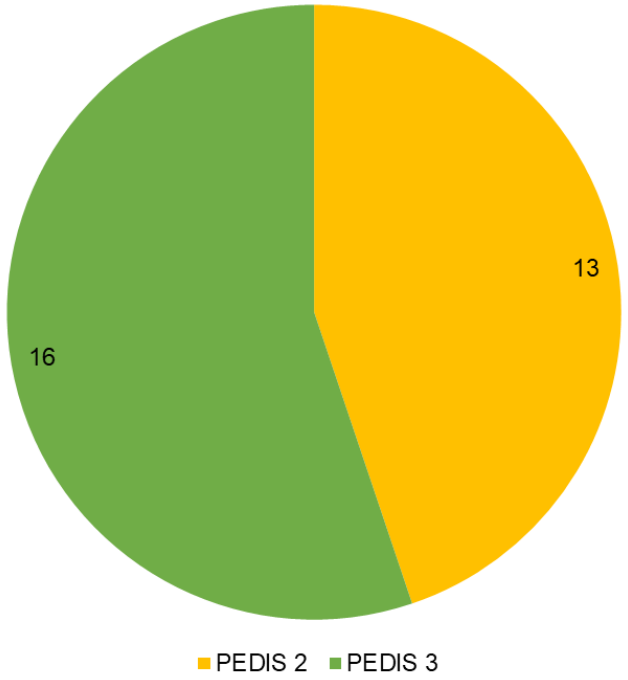
Raadpleeg paragraaf 3.1.1 op p. 17 voor instructies over hoe deze tabel te lezen.

Revascularized

PEDIS-2 vs PEDIS-3 patients that were revascularized (n=423) in 37 MDFC



Major amputation in PEDIS-2 vs PEDIS-3 patients that were revascularized (n=29) in 37 MDFC



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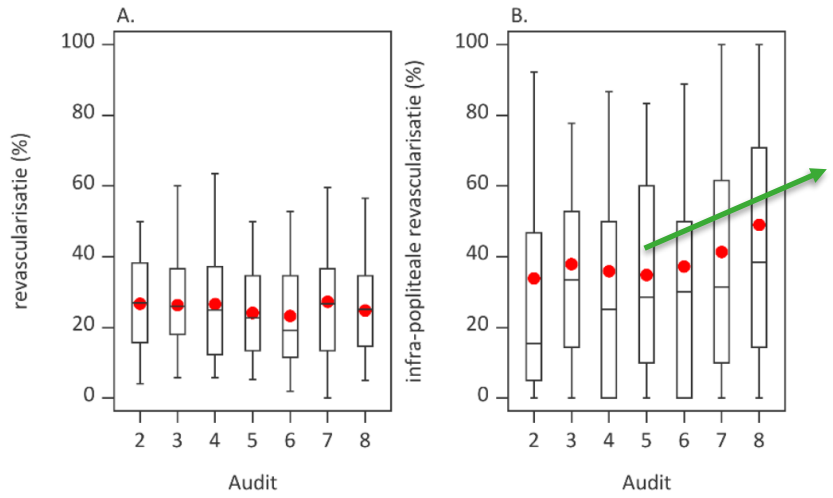
Revascularisation 2/2

Tabel 31: Revascularisatieniveau bij patiënten met een diabetisch voetulcus, audits 2-8

	Audit 2 (N=248)	Audit 3 (N=401)	Audit 4 (N=457)	Audit 5 (N=454)	Audit 6 (N=419)	Audit 7 (N=438)	Audit 8 (N=1.977)	Trend
Revascularisatieniveau, bekend	200 (80,2)	342 (84,6)	383 (84,3)	377 (83,1)	366 (87,5)	392 (89,2)	468 (94,4)[f]	
Algemene percentages								
Aortoiliacaal	10 (4,9)	27 (7,9)	47 (12,6)	46 (12,2)	34 (9,3)	47 (12,5)	66 (14,0)	++
Femoropopliteaal	125 (62,3)	208 (61,8)	234 (61,3)	269 (71,1)	261 (71,2)	269 (65,1)	293 (61,5)	
Infrapopliteaal	84 (41,9)	152 (43,2)	164 (42,3)	158 (42,7)	156 (43,7)	181 (47,1)	243 (53,0)	
Rekening houdend met combinaties								
Alleen aortoiliacaal	8 (4,0)	18 (5,4)	23 (6,4)	21 (5,4)	12 (3,2)	20 (6,1)	26 (5,8)	
Alleen femoropopliteaal	106 (53,3)	167 (50,1)	182 (47,8)	180 (47,0)	185 (49,7)	174 (42,6)	180 (37,4)	-
Alleen infrapopliteaal	67 (33,7)	115 (32,5)	120 (30,8)	85 (23,0)	90 (24,7)	98 (27,5)	144 (31,7)	
Aortoiliacaal + femoropopliteaal	2 (0,9)	5 (1,4)	14 (3,5)	18 (4,9)	13 (3,5)	17 (4,2)	19 (3,9)	++
Aortoiliacaal + infrapopliteaal	0 (0,0)	1 (0,3)	6 (1,5)	2 (0,5)	3 (0,9)	5 (1,3)	5 (1,1)	
Femoropopliteaal + infrapopliteaal	17 (8,1)	33 (9,5)	34 (8,8)	66 (17,9)[d]	57 (16,4)	73 (17,4)	78 (16,9)	++
Aortoiliacaal + femoropopliteaal + infrapopliteaal	0 (0,0)	3 (0,8)	4 (1,2)	5 (1,3)	6 (1,7)	5 (0,9)	16 (3,3)	

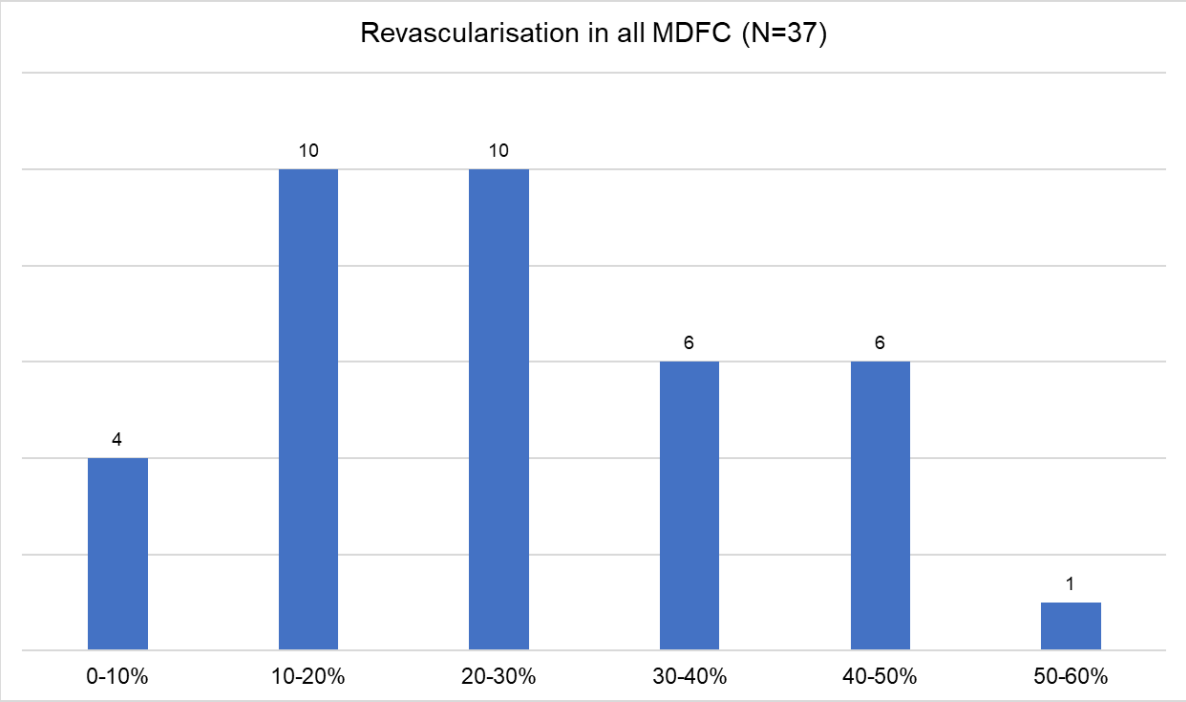
Raadpleeg paragraaf 3.1.1 op p. 17 voor instructies over hoe deze tabel te lezen.

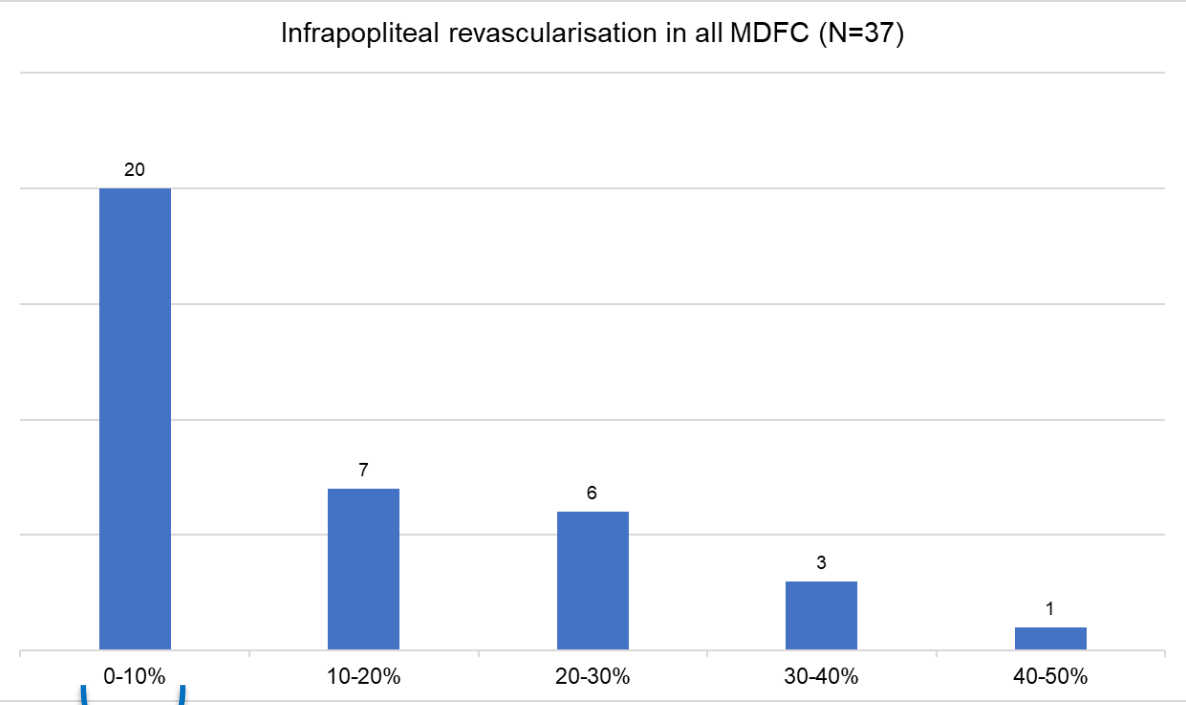
BTK revasc gaining popularity



(Infrapopliteal) revascularisation: between centres

AUDIT 8: MDFC (n = 37)
% of DF-patients that were revascularized
246 BTK targeted in **500** revascularisations





Very low BTK treatment = Quality issue?

Expensive? Time consuming? Know-how? Infrastructure? (Hybrid room)
Revasc. Dogma? inflow (upstream) repair vs (out)flow-limiting lesion (‘angiosome / woundsome’)

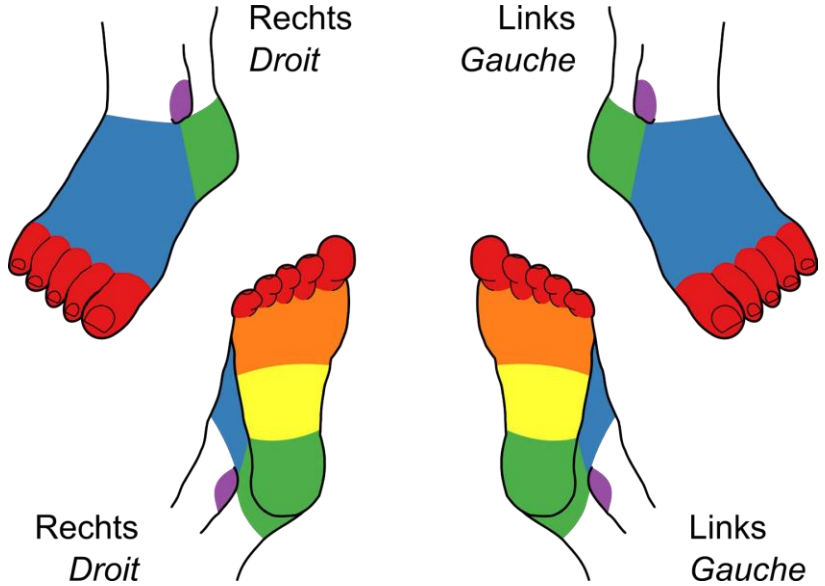
IQED-Foot: Unanswered questions

Quality outcome: limb salvage (major amputation)

- minor amputation ≠ treatment (or revasc.) failure!

Wound topography: hindfoot MUST heal (revasc. succes)

- Compare: heel + PAD vs toe/amputation + PAD
- Against outcome and revascularisation attempt
  - Aggressive revasc warranted for hindfoot tissue defects



Timing data registration: intake vs 7 months

- Bias? ‘no revascularisation’ because not planned at intake, but during follow-up

PAD/CLI outcome vs no PAD?

Advisories

PAD

- clinical diagnosis, simple tests (doppler, wave form)
- low threshold for suspicion (see IWGDF guidelines)
- beware CT/MRI protocols: false negatives are frequent

Foot attack

- compensate late referral with swift vascular workup + revascularisation (no IQED-foot data)

Revascularisation strategy

- endovascular predominantly (reasons…)
- popliteal pulsation present: green light for endovascular first
- ‘flow-limiting lesion’ vs ~~‘Inflow first, then (BTK) Outflow’~~
- BTK targeting: identify inhibitors

Please select 1 option.

Complete the following statement:
Which situation fits best? 'In our MDFC, the vascular surgeon ...'

Please select 1 option.

Peripheral arterial disease / critical limb ischemia in diabetic foot patients can be multi level (iliac, femoral, SFA, popliteal, BTK, ankle and foot). Which revascularisation approach suits me best?

A patient presents with a chronic wound and peripheral arterial disease is clinically suspected. A vascular workup, imaging of the arteries and – eventually – a revascularisation is required.

Estimate the average number of days between first consultation and revascularisation.

Please answer with a number (1, 2, 3, ...) of days.

THE PRACTICE OF OFFLOADING: THE GOOD, THE BAD AND THE UGLY

Prof Dr Frank Nobels (diabetologist, AZORG Aalst), Dr Patrick Lauwers (vascular surgeon, UZ Antwerp), Prof Dr Giovanni Matricali (orthopaedic surgeon, UZ Leuven)

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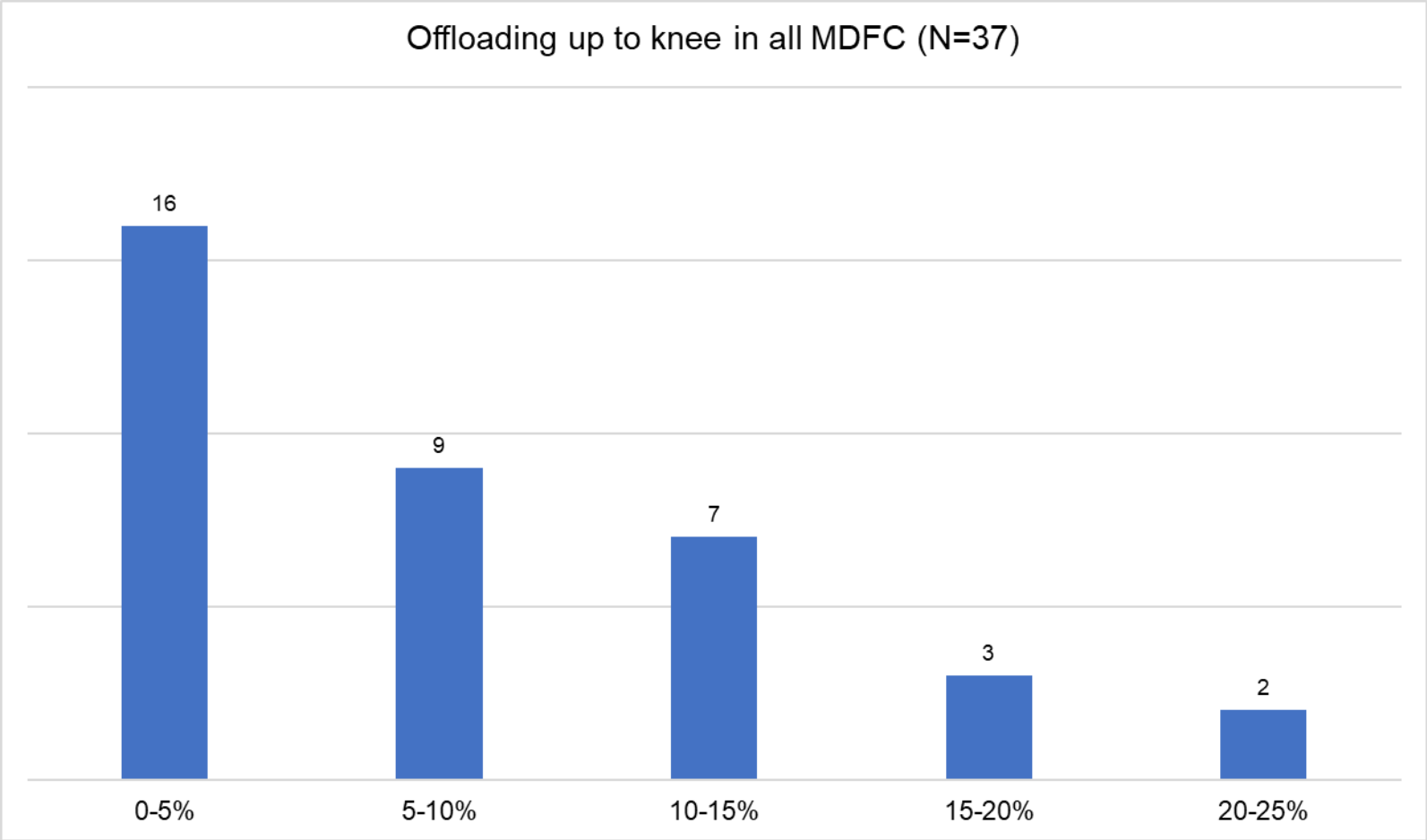
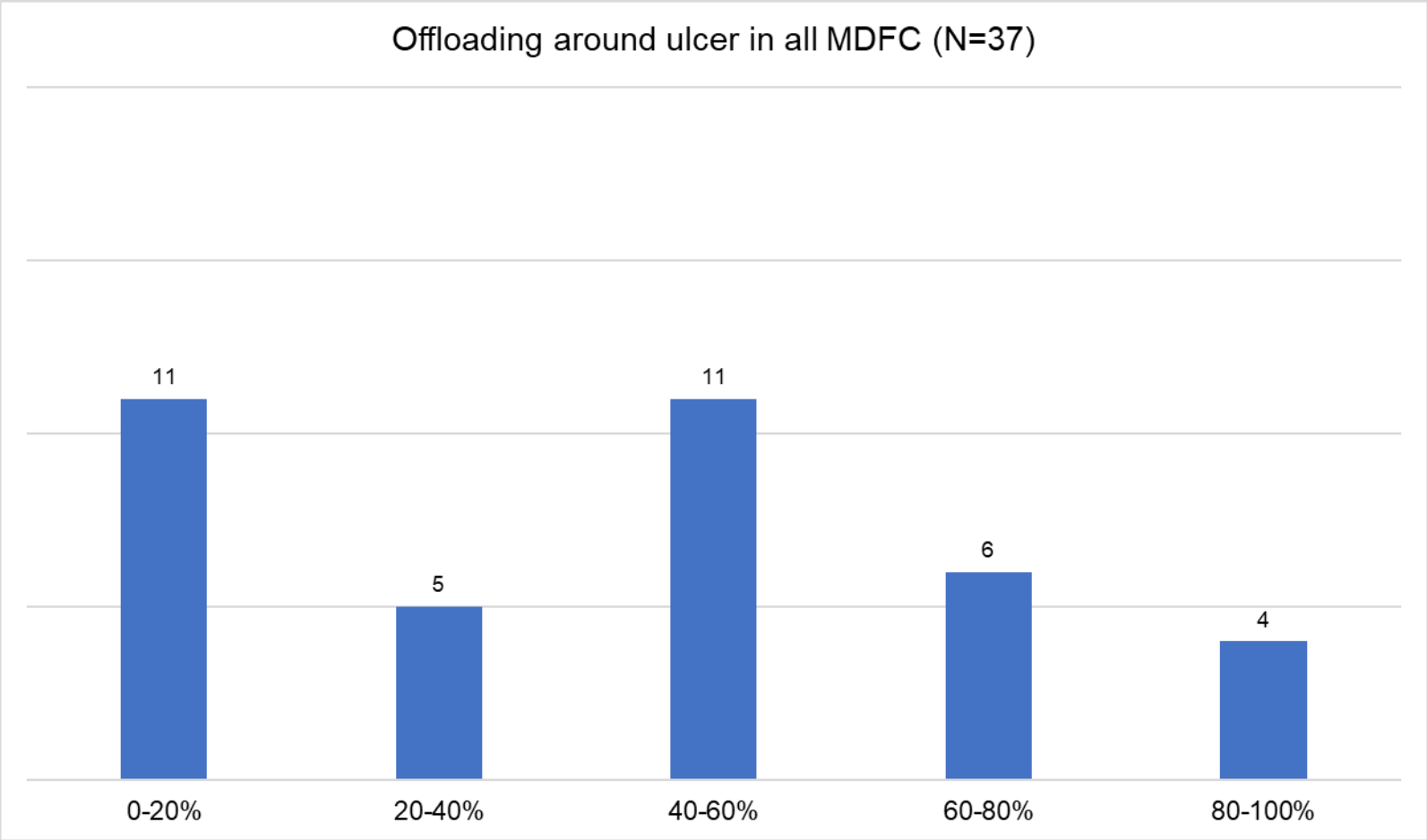
Offloading up to the knee



Offloading around the ulcer



Offloading: IWGDF guideline 2023

ISDF conference Den Haag, 2023

Case: MG ♀ 75y

- T2D
- Ethylism
- neuropathy, no vascular disease
- has been walking around with wound for some time
- has old semi-orthopaedic shoes, which she does not tighten adequately
- husband brain tumour, lots of worries

?

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Case: MG ♀ 75y

- T2D
- Ethylism
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- has old semi-orthopaedic shoes, which she does not tighten adequately
- husband brain tumour, lots of worries

?

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Felt + cotton wool + velpeau + woundshoe

reasonable offloading
removable, but not easy to do this unnoticed

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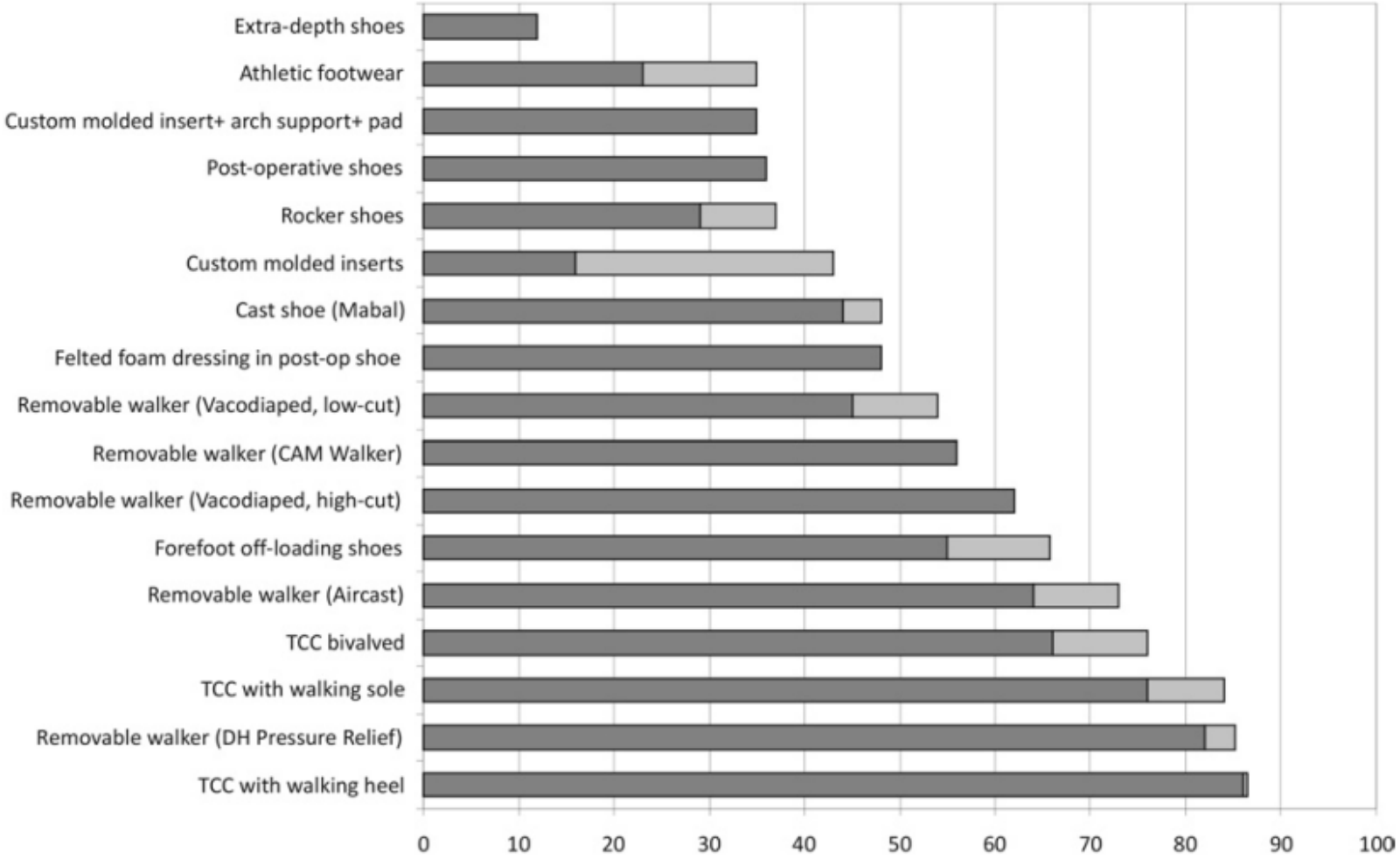
Offloading: pressure relief



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Offloading: gold standards not always feasible

	Standard care (n=134)	LeucoPatch plus standard care (n=132)	Total (n=266)
Affected foot position, n (%)§			
Total forefoot	99 (74%)	108 (82%)	207 (78%)
Plantar forefoot	54 (40%)	57 (43%)	111 (42%)
Hind foot	35 (26%)	24 (18%)	59 (22%)
Type of offloading			
Bedbound or immobile	3 (2%)	4 (3%)	7 (3%)
Normal footwear	10 (7%)	14 (11%)	24 (9%)
Normal footwear plus fitted insoles or inserts	6 (4%)	6 (5%)	12 (5%)
Fitted footwear or orthoses	35 (26%)	38 (29%)	73 (27%)
Padded slipper or shoe	27 (20%)	28 (21%)	55 (21%)
Removable cast or device for foot	34 (25%)	31 (23%)	65 (24%)
Removable cast or device for lower leg	25 (19%)	17 (13%)	42 (16%)
Non-removable cast or device for foot	1 (1%)	3 (2%)	4 (2%)
Non-removable cast or device for lower leg	4 (3%)	6 (5%)	10 (4%)

LeucoPatch trial. Game F, et al. Lancet Diabetes Endocrinol 2018

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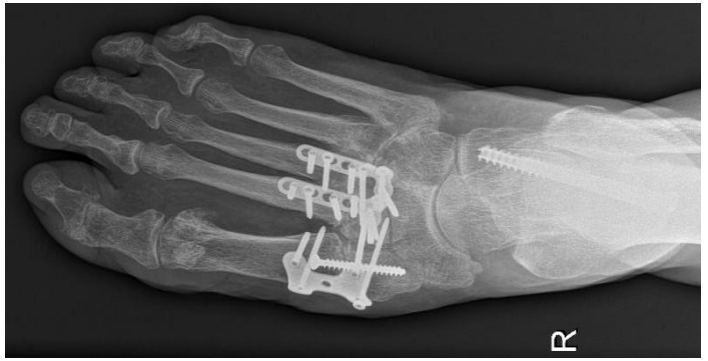
Case: DWM ♀ 68y

presentation 27/02/2025

- T2D
- neuropathy, no vascular disease
- reconstruction Lisfranc right foot for Charcot (3/2019)
- obese, arthrosis, difficult gait
  → TCC not feasible

?



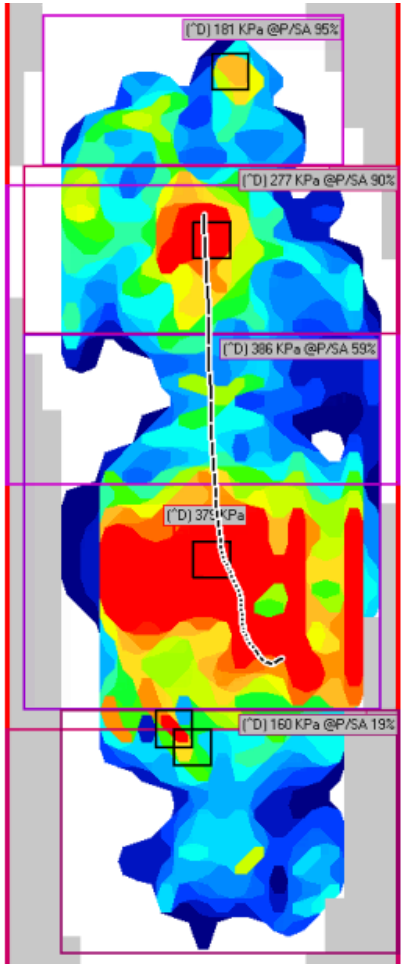
Case: DWM ♀ 68y

presentation 27/02/2025

- T2D
- neuropathy, no vascular disease
- reconstruction Lisfranc right foot for Charcot (3/2019)
- obese, arthrosis, difficult gait
  → TCC not feasible

punctual use of orthopaedic shoes, also indoors !

→ 31/3 healed



Importance of biomechanics to guide footwear and, if necessary, corrective foot surgery

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Offloading: IWGDF guideline 2023

ISDF conference Den Haag, 2023

Case: A ♀ 60y

- T2D (2003)
- obese (BMI 47), Hashimoto, HD, sleep-apnea
- neuropathy, increased ABI
- history of multiple foot problems
  - amputation R hallux & D4
  - lisfranc Charcot R
  - multiple ulcera
  - correction hammertoes
- difficult coping
- has orthopaedic shoes, but….

?

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Case: A ♀ 60y

- Recurrent development of ulcera bilateral (several locations)
- Recurrent treatment with TCC, felt, acute phase shoes, hammer toe correction, …
- > always good result
- Orthopaedic shoes since 2015

- >> In Shoe pressure gait analysis?
- Compliance?

Case: B ♂ 70y

- T2D (2006)
- Obese, high BP, metabole syndrome
- neuropathy, sufficient ABI & TcpO2
- Difficult coping
- History of multiple foot problems (R)
- Multiple ulcera
- MTP1 desis + pseudarthrosis
- Short gastric
- >> Correction hammertoes / plantar overload
- has orthopaedic shoes, but…..

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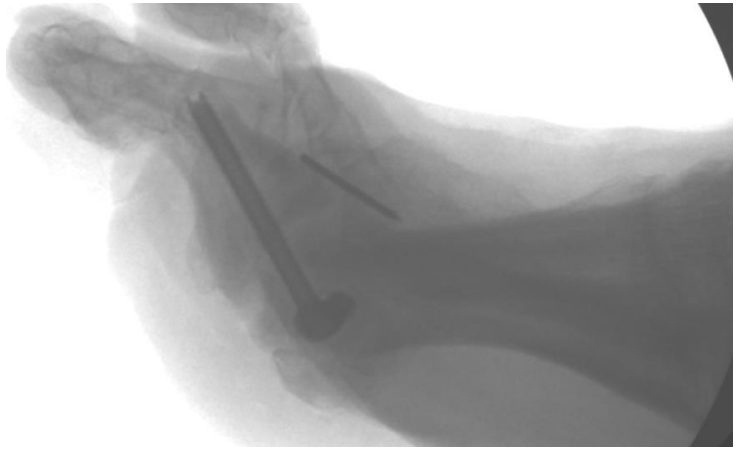
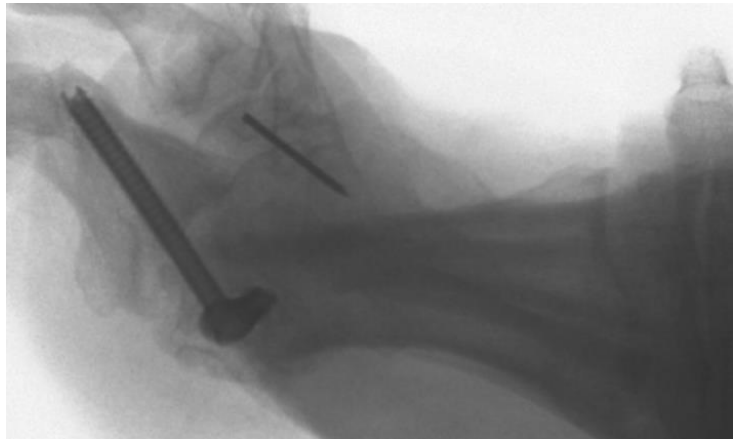
Case: B ♂ 70y

- After several years a new ulcer
- Again short AT



- New surgical correction
- >> MIS shaving medial sesamoid; tricut AT lengthening



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Importance of biomechanics to guide footwear and, if necessary, corrective foot surgery

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THE PODIATRIST IN THE DIABETIC FOOT CLINIC: ROLE, CHALLENGES AND FUTURE

Mr Cédric Lannoo (podiatrist, UZ Ghent), Ms Sabine De Bruyne (podiatrist, AZ Sint Lucas Ghent), Prof Dr Eveline Dirinck (diabetologist, UZ Antwerp)

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Aim

- To evaluate the role of the podiatrist in the multidisciplinary diabetic foot clinics (MDFC)

- To learn from good practices and move forward towards an even better integration of the podiatrist in the MDFC

The podiatrist in the MDFC

The field of podiatry is considered one of the most important disciplines in the interdisciplinary care of the MDFC

- Expertise in the foot
- Specific training in biomechanics

Favourable impact on patient outcome

- Regarding major amputations (Blanchette et al., 2020)
- Healing of the ulcer and time until healing is advanced (Blanchette et al., 2018)

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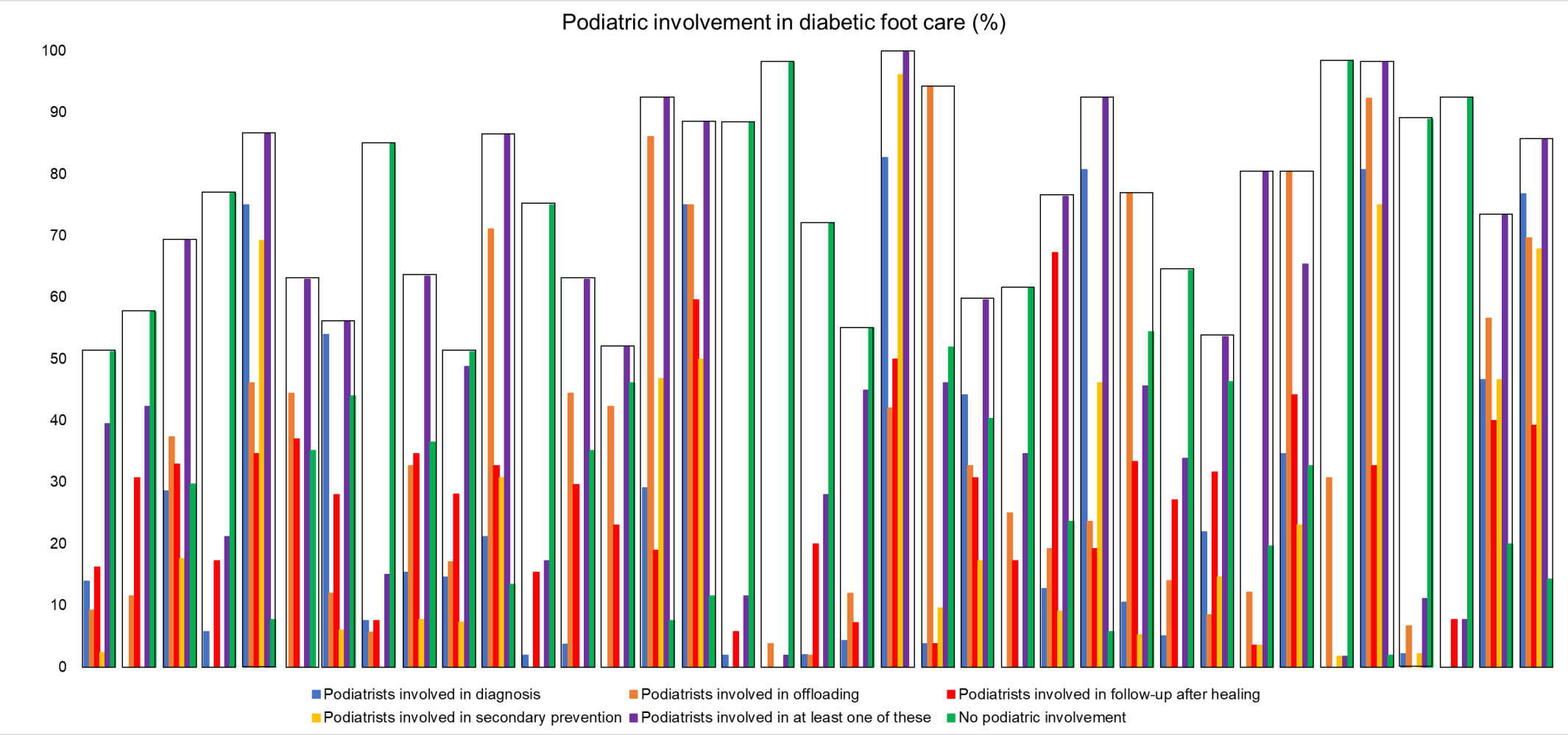
Please select 1 option.

Who is Who?

ⓘ Start presenting to display the poll results on this slide.

Podiatric involvement in diabetic foot care



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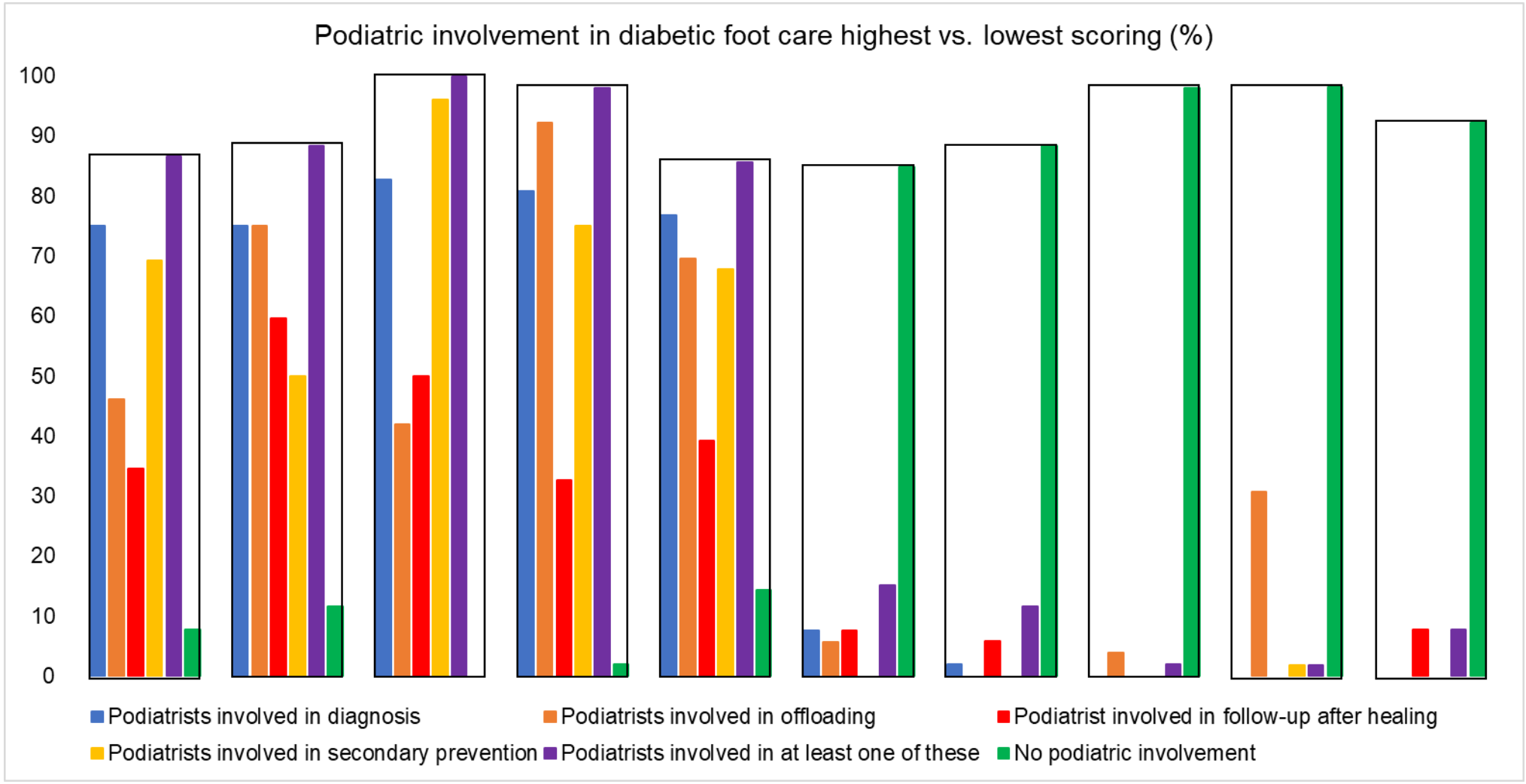
Podiatric involvement in diabetic foot care



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A podiatrist is an obligated (required) member of the MDFC.
Why is there limited or no involvement in some of the MDFC?

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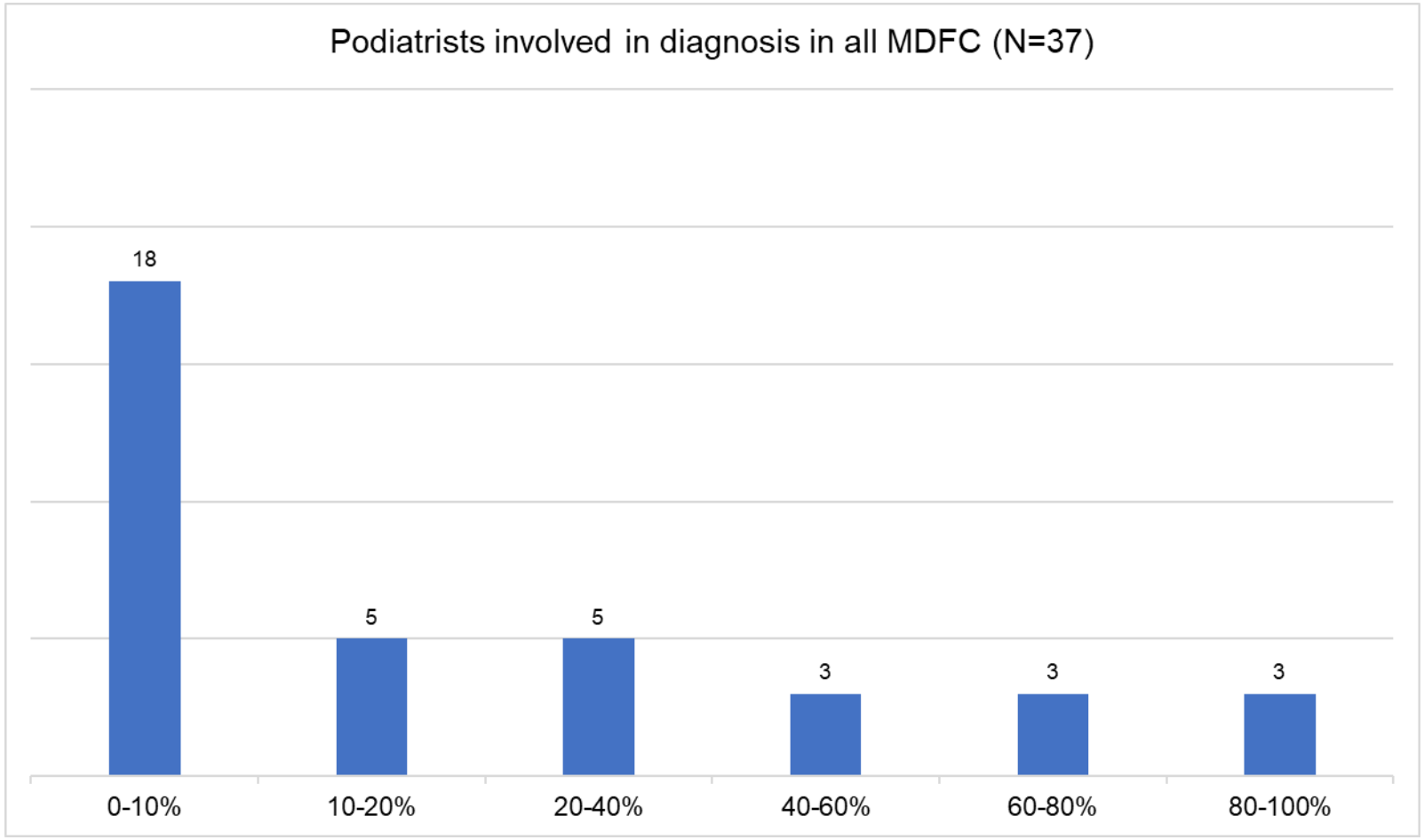
Podiatric involvement in diagnosis



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Please select all that apply.

What tasks are you involved in as a podiatrist?

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Please select 1 option.

Do you use any supportive consultation (paramedic involvement only) during foot clinic hours?

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Please select all that apply.

Who takes care of the intermediate foot injuries outside the working hours of the MDFC?

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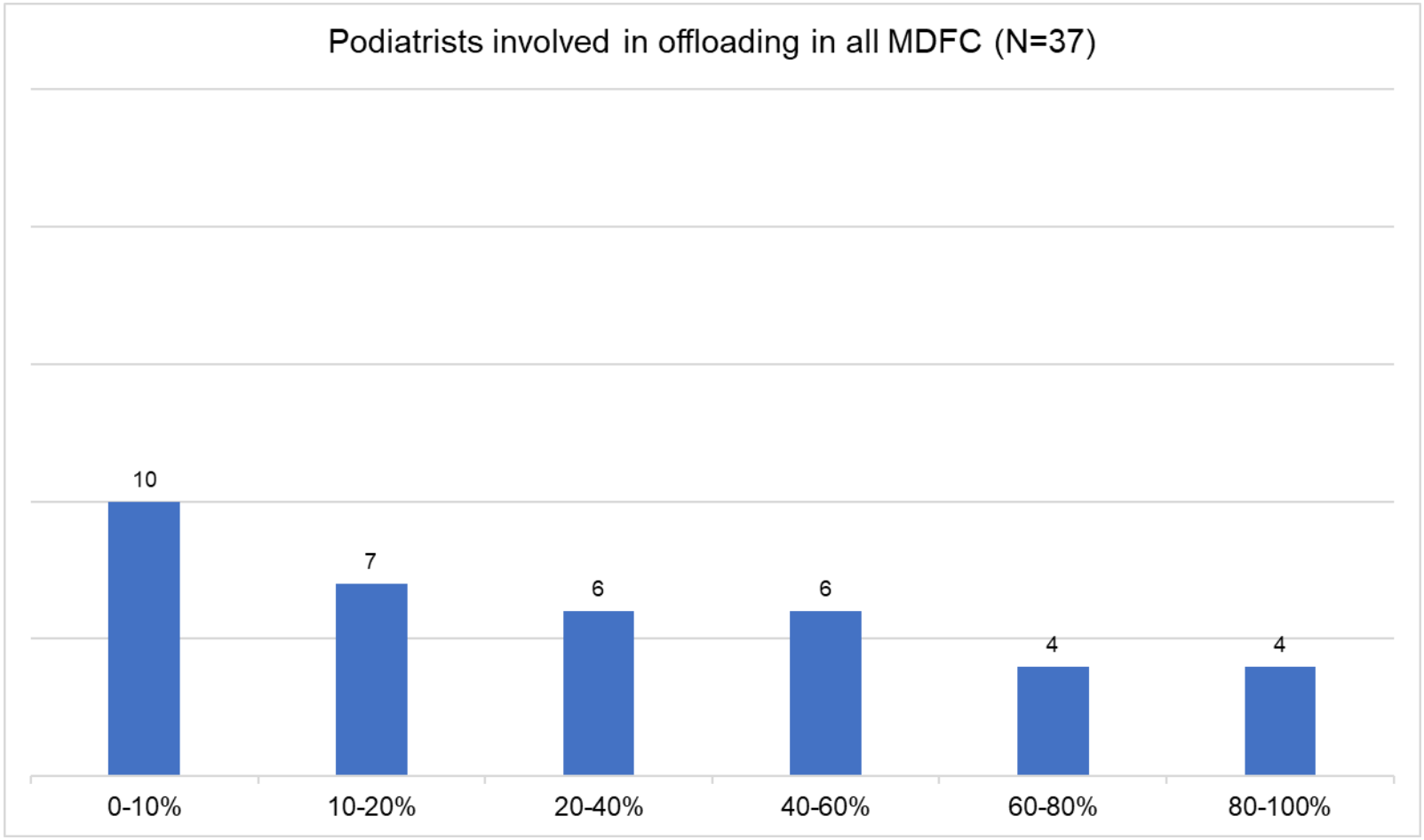
Podiatric involvement in offloading



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Please select all that apply.

Who in your MDFC removes calluses around a wound?

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Please select all that apply.

Who in your MDFC places felt around a wound if necessary?

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Please select all that apply.

Who in your MDFC RECOMMENDS the type of offloading DURING healing?

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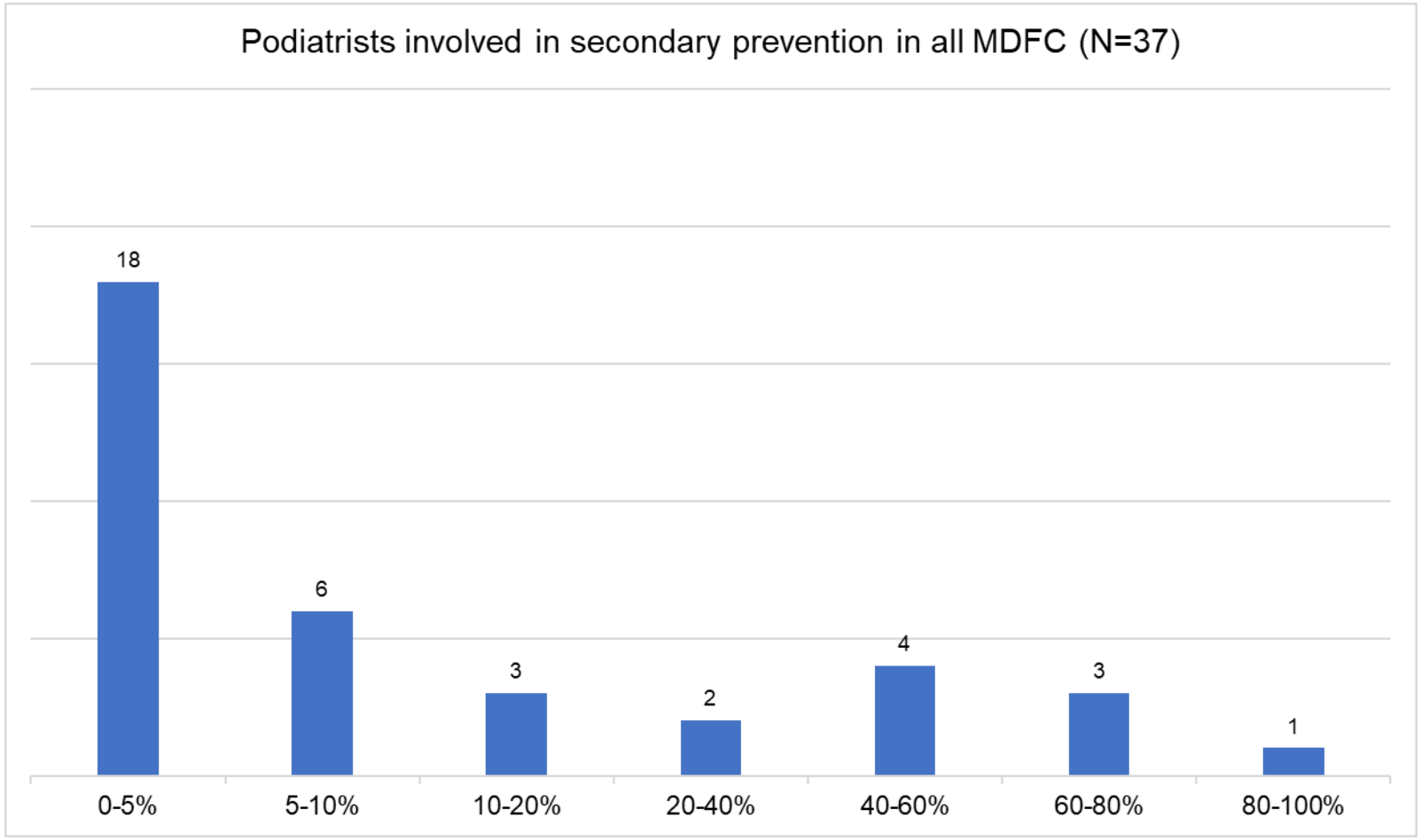
Podiatric involvement in secondary prevention



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Please select all that apply.

Who in your MDFC RECOMMENDS the type of offloading AFTER healing?

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Please select all that apply.

Who in your MDFC RECOMMENDS insoles to the patients?

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Please select all that apply.

Who in your MDFC RECOMMENDS (semi-) orthopaedic shoes to the patients?

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Please select 1 option.

At what moment is the podiatrist in first line most involved?

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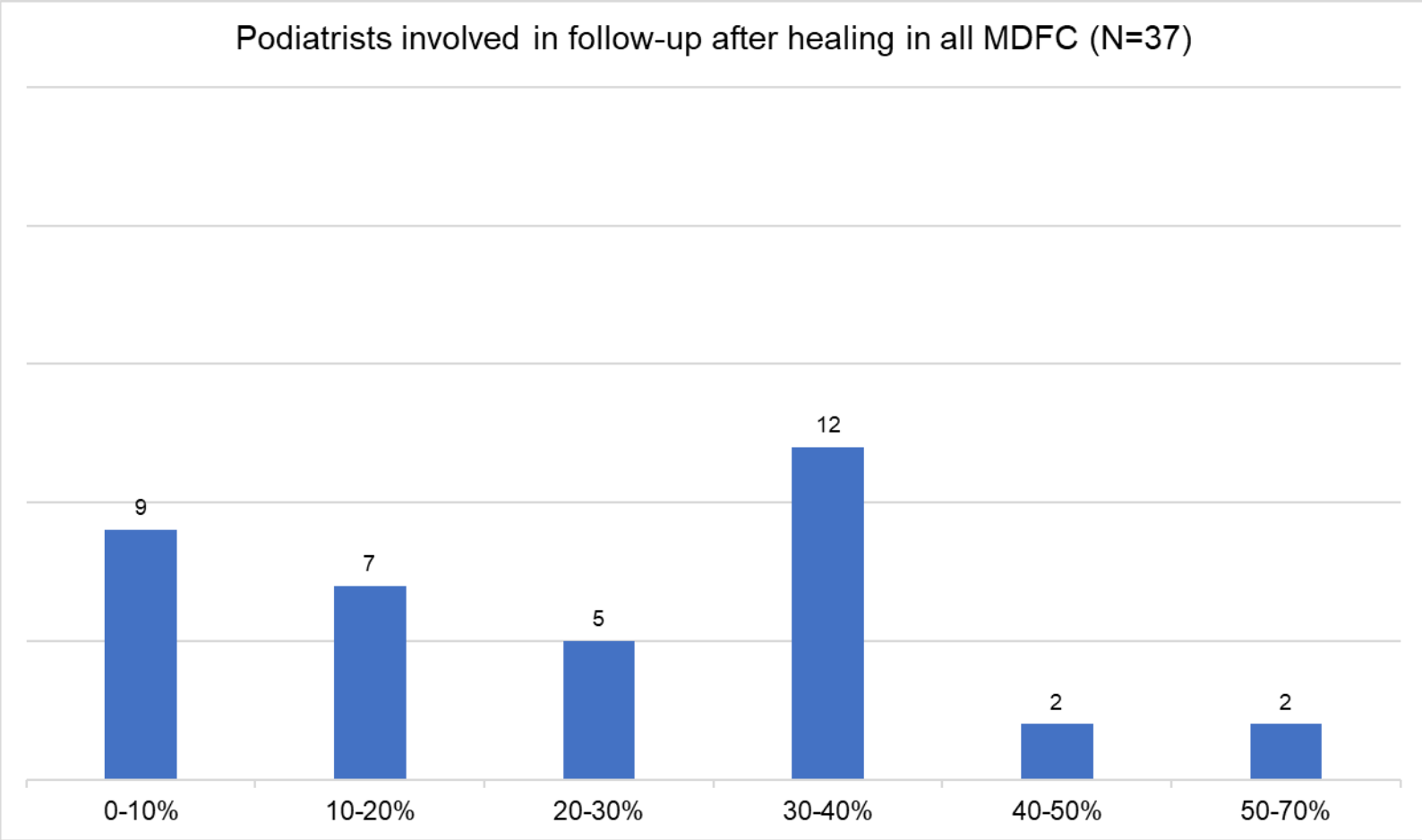
Podiatric involvement in follow-up after healing



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Please select all that apply.

Who INFORMS the patient about podiatric follow-up after wound healing?

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Please select all that apply.

What kind of information is given to the patient?

ⓘ Start presenting to display the poll results on this slide.

Kringproject diabetes

The ‘kringproject diabetes’ https://www.podologie.be/kringwerking was started by the RBPA and financed by the Flemish government with the aim of

- Developing a quality framework for integrated care for diabetic patients with at higher risk of foot problems, based on the IWGDF guidelines https://iwgdfguidelines.org/guidelines-2023/
- Realising the prevention of foot injuries through the development of standardised screening protocols for the different actors in primary foot care in Flanders
- With the cooperation of the ‘Commissie Voet’ active within the Diabetes Liga

ROYAL BELGIAN PODIATRY ASSOCIATION

KRINGWERKING PODOLOGIE

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Bibliography

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- Blanchette V, Hains S, Cloutier L. Establishing a multidisciplinary partnership integrating podiatric care into the Quebec public health-care system to improve diabetic foot outcomes: A retrospective cohort. Foot Edinb Scotl. 2019;38:54-60.

CLOSING REMARKS

Margot Buyle PhD and Dr Michel Vandenbroucke

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What have we learned today (1/6)

- We saw/heard 3 beautiful presentations dealing with the results of IQED-Foot audit 8
- Most of you participated in vivid but fruitful discussions
- Nevertheless, we end up with a lot of paradoxical situations

What have we learned today (2/6)

VASCULAR STATUS:

1. We all perform clinical vascular examination, followed by appropriate additional testing

2. But we do not apply our own standards of care:
    - ‘Gold standards’ interventions are only chosen in a relatively small % of the cases
    - It remains somewhat unclear who is taking the decisions about the type of intervention that is needed
    - Questions remain which approach is most suitable: upper leg versus BTK
    - There seems to be no consensus regarding follow-up: timing, initiative, responsibility, outcome registration, adverse effects management, …
    - We all welcome the foot attack principle, nevertheless semi-urgent steps are not taken swiftly

What have we learned today (3/6)

OFFLOADING:

1. We all are aware of the utmost importance of offloading

2. But we do not apply our own standards of care:
    - ‘Gold standards’ interventions like TCC are hardly practiced
    - We deal with pressure overload using inspection instead of measuring it, f.i. using in shoe pressure
    - Although we are aware that patients do not always answer correctly, we rely on these answers in deciding on further diagnostic and therapeutic measures
    - We are aware of the surgical possibilities of in foot pressure relief but remain, like the patients, reluctant to practice them

What have we learned today (4/6)

COLLABORATION WITH PODIATRISTS:

1. We all agree that we need podiatrists in our multidisciplinary teams

2. But in practice:
    - Audit 8 revealed large variety among MDFC
    - It remains unclear which tasks can be delegated to the podiatrists
    - There also seems to be no consensus among podiatrists themselves about their role in the team
    - Podiatrists are insufficiently involved in decision-making during follow-up
    - Over the last 2 decades, working in a MDFC became less attractive for podiatrists

What have we learned today (5/6)

FUTURE:

1. We appreciate new challenges to be pursued, like increasing number of patients and additional evaluations such as nutritional status, degree of frailty, promoting mobility, …

2. But in practice:
    - Most of us lack the time to cope with this
    - We see an increase in the number of ‘daily life tasks’ like reporting, registering, prescribing, applying for agreement/reimbursement, informing patients and relatives, …

What have we learned today (6/6)

- We saw/heard 3 beautiful presentations dealing with the results of IQED-Foot audit 8
- Most of you participated in vivid but fruitful discussions
- Nevertheless, we end up with a lot of paradoxical situations

Luckily we can find some tools and answers in the *barrier survey* results: Based on this survey, we can advise all MDFC to **choose one or more focus points** from this survey and **create a platform** in our MDFC in order to **find and implement a solution**.

Reasons General Higher Rates

Reasons General Lower Rates

→ Next steps?

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Thank you!

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