

An overview of recommendations on risk assessment and preventative interventions in the Australian guideline and IWGDF guidance

AUSTRALIAN GUIDELINE	IWGDF GUIDANCE
Part A – Risk Assessment	
EBR 1: Assess all people with diabetes and stratify their risk of developing foot complications. (Grade C)	1. To identify a person with diabetes at risk for foot ulceration, examine the feet annually to seek evidence for signs or symptoms of peripheral neuropathy and peripheral artery disease. (GRADE recommendation: strong; Quality of evidence: low)
EO 1: Any suitably trained healthcare professional may perform the risk assessment.	
EBR 2: Assess risk stratification by inquiring about previous foot ulceration and amputation, visually inspecting the feet for structural abnormalities and ulceration, assessing for neuropathy using either the Neuropathy Disability Score or a 10g monofilament and palpating foot pulses. (C)	2. In a person with diabetes who has peripheral neuropathy, screen for: a history of foot ulceration or lower-extremity amputation; peripheral artery disease; foot deformity; pre-ulcerative signs on the foot; poor foot hygiene; and ill-fitting or inadequate footwear. (Strong; Low)
EBR 3: Stratify foot risk in the following manner (C): <ul style="list-style-type: none"> - “low risk”- people with no risk factors and no previous history of foot ulcer/amputation - “intermediate risk”- people with one risk factor (neuropathy, peripheral arterial disease or foot deformity) and no previous history of foot ulcer/amputation - “high risk” - people with two or more risk factors (neuropathy, peripheral arterial disease or foot deformity) and/or a previous history of foot ulcer/amputation 	IWGDF risk classification: 0 - No peripheral neuropathy 1 - Peripheral neuropathy 2 - Peripheral neuropathy with peripheral artery disease and/or a foot deformity 3 - Peripheral neuropathy and a history of foot ulcer or lower-extremity amputation
EO 2: Until adequately assessed all Aboriginal and Torres Strait Islander people with diabetes are considered to be at high risk of developing foot complications and therefore will require foot checks at every clinical encounter and active follow-up.	
EO 3: In people stratified as having low-risk feet (where no risk factors or previous foot complications have been identified), foot examination should occur annually.	Screening based on risk classification: IWGDF 0: Once a year
EO 4: In people stratified as having intermediate-risk or high-risk feet (without current foot ulceration), foot examination should occur at least every 3 to 6 months.	Screening based on risk classification: IWGDF 1: Once every 6 months IWGDF 2: Once every 3-6 months IWGDF 3: Once every 1-3 months
Part B – Prevention Interventions	
EBR 4: People assessed as having “intermediate risk” or “high risk” feet should be offered a foot	9. To prevent a recurrent foot ulcer in an at-risk patient with diabetes, provide integrated foot care,

protection program. A foot protection program includes foot care education, podiatry review and appropriate footwear. (C)	which includes professional foot treatment, adequate footwear and education. This should be repeated or re-evaluated once every one to three months as necessary. (Strong; Low)
EO 5: Podiatry review is an important component of a foot protection program. However, in settings where this is not possible, a suitably trained health care worker may undertake a review of the feet.	3. Treat any pre-ulcerative sign on the foot of a patient with diabetes. This includes: removing callus; protecting blisters and draining when necessary; treating ingrown or thickened toe nails; treating haemorrhage when necessary; and prescribing antifungal treatment for fungal infections. (Strong; Low)
EO 6: Foot care education should be provided to all people with diabetes to assist with prevention of foot complications.	8. To prevent a first foot ulcer in an at-risk patient with diabetes, provide education aimed at improving foot care knowledge and behaviour, as well as encouraging the patient to adhere to this foot care advice. (Weak; Low)
	4. To protect their feet, instruct an at-risk patient with diabetes not to walk barefoot, in socks, or in thin-soled standard slippers, whether at home or when outside. (Strong; Low)
	5. Instruct an at-risk patient with diabetes to: daily inspect their feet and the inside of their shoes; daily wash their feet (with careful drying particularly between the toes); avoid using chemical agents or plasters to remove callus or corns; use emollients to lubricate dry skin; and cut toe nails straight across. (Weak; Low)
	6. Instruct an at-risk patient with diabetes to wear properly fitting footwear to prevent a first foot ulcer, either plantar or non-plantar, or a recurrent non-plantar foot ulcer. When a foot deformity or a pre-ulcerative sign is present, consider prescribing therapeutic shoes, custom-made insoles, or toe orthosis. (Strong; Low)
<i>There was insufficient evidence to determine the effectiveness of therapeutic footwear (2 average quality trials) for the prevention of foot complications.</i>	7. To prevent a recurrent plantar foot ulcer in an at-risk patient with diabetes, prescribe therapeutic footwear that has a demonstrated plantar pressure relieving effect during walking (i.e. 30% relief compared to plantar pressure in standard of care therapeutic footwear), and encourage the patient to wear this footwear. (Strong; Moderate)
<i>Expert working group felt there was insufficient evidence (due to small sample sizes) and concerns regarding feasibility to make a recommendation for home-based temperature monitoring.</i>	10. Instruct a high-risk patient with diabetes to monitor foot skin temperature at home to prevent a first or recurrent plantar foot ulcer. This aims at identifying the early signs of inflammation, followed by action taken by the patient and care provider to resolve the cause of inflammation. (Weak; Moderate)
<i>Not included in the systematic review.</i>	11. Consider digital flexor tenotomy to prevent a toe ulcer when conservative treatment fails in a high-risk patient with diabetes, hammertoes and

	either a pre-ulcerative sign or an ulcer on the toe. (Weak; Low)
<i>Given the limited clinical impact and small numbers studied, no recommendation has been developed.</i>	12. Consider Achilles tendon lengthening, joint arthroplasty, single or pan metatarsal head resection, or osteotomy to prevent a recurrent foot ulcer when conservative treatment fails in a high-risk patient with diabetes and a plantar foot ulcer. (Weak; Low)
<i>Nerve decompression studies excluded from the systematic review.</i>	13. Do not use a nerve decompression procedure in an effort to prevent a foot ulcer in an at-risk patient with diabetes, in preference to accepted standards of good quality care. (Weak; Low)
Note: EBR = Evidence-Based Recommendation; EO = Expert Opinion. Text in <i>Italics</i> refers to the guidelines, but is not a specific recommendation.	