

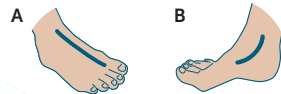
### Questions to ask your patient

- 1 Have you had any foot problems, including blisters, open wounds or pain?
- 2 Have you experienced any numbness or tingling in your feet?
- 3 Do you experience pain or tightness in your calves when walking? Is it relieved by stopping?
- 4 Have you ever seen a vascular surgeon, or had any operations to improve the circulation in your feet and legs?
- 5 Are you on renal replacement therapy?
- 6 Do you see a podiatrist? NHS or private? (Do they have HCPC registration?)
- 7 Is your sight impaired – can you see well enough to cut your own nails?
- 8 Can you reach to cut your own nails safely? If not, is there a carer or relative that can assist with your foot care needs?
- 9 Do you smoke?
- 10 Do you work?
- 11 How active are you? Do you take regular exercise?

### Examination

- 1 Ask about any previous amputation or ulceration. (If yes, ask if diabetes related.)
- 2 Check both feet for areas of current ulceration, heat, redness or swelling.
- 3 Check the general shape of the feet for any structural abnormalities and prominent joints, such as clawed toes or hallux valgus (bunions). Do they have chronic Charcot foot?
- 4 Check both feet for any areas of significant callus or dry skin, paying particular attention to the heel area.
- 5 Check between the toes for problems such as athlete's foot, soft corns or fissures.
- 6 Check for any nail conditions such as ingrowing, fungal or particularly thick or curved nails that could make self-care difficult.
- 7 Check if wearing suitable footwear – is it the correct size, shape and depth to accommodate their foot shape? Are they excessively worn or showing signs of rubbing?
- 8 Check the patient's circulation to their feet. (See Illustration 1)
- 9 Check if the patient still has protective sensation (ie, would they feel a stone in their shoe?). (See Illustrations 2 and 3)

#### Illustration 1: Checking circulation



There are two pulses we can palpate for (feel for) in each foot: the dorsalis pedis (A) and the posterior tibial (B).

**NOTE:** The dorsalis pedis pulse is absent in about 10% of the population.

#### Illustration 2: Checking sensation

Use a reputable 10 gram monofilament (Bailey, or Owen & Mumford as these are calibrated).



#### Illustration 3: Places to check sensation

Check sensation in all six places on both feet

**IMPORTANT:** Absent sensation at any site = peripheral neuropathy and increased risk



### Risk classification and next actions

From the results of checklists 1 and 2 and the patient's records, calculate a score below for the patient. Use the total to classify the patient's risk in the coloured table

Risk Factor	Score
Current ulceration, infection, gangrene or acute Charcot foot	30
Previous ulceration	10
History of amputation	10
Renal replacement therapy	10
Poor circulation	5
Peripheral neuropathy	5
Significant callus formation	5
Foot deformity/chronic Charcot	5
Poor glycaemic control	1
Inability to self care	1
Poor vision	1
Smoker	1
History of drug or alcohol abuse	1

Score	Risk Classification	Action
30 +	Ulcerated Foot or Foot Emergency	Immediate referral to specialist diabetes multi-disciplinary team.
10-30	High-Risk Foot	Refer patient to specialist foot team for assessment and ongoing management. Review foot screen in 3-6 months. Supply emergency contact numbers. Supply advice leaflets on warning signs of infection and self care.
5-10	Moderate-Risk Foot	Refer patient to local podiatry team for ongoing management. Review foot screen in 6-12 months. Supply emergency contact numbers. Supply advice leaflets on warning signs of infection and self care.
0-5	Low-Risk Foot	Advise patient on self care, including checking feet daily, use of moisturiser daily and review foot screen in 12 months.

Advise patients to moisturise their feet daily. For areas of dry, hard and cracked skin or callus, recommend patients use a urea-based emollient – 25% for effective treatment, 10% for everyday maintenance.



### When to refer to the specialist Multi-disciplinary Team (MDT)

ALL diabetic foot ulcers should be reviewed initially by the specialist MDT no matter how insignificant they may seem. Often small, superficial clean ulcers are not considered serious enough to require a referral, however early intervention is vital for preventing them escalating into a foot emergency.

Photograph **A** shows a foot that is clearly infected and in need of referral.

Photograph **B** shows a less serious foot ulcer but still requires referral to ensure appropriate management plans are in place.

If we can improve the identification of feet that need referral, and then make those referrals in a timely manner, we can reduce diabetic foot complications, including amputation, and improve patient outcomes.