

**Secondary podiatric prevention a so forgotten issue and probably one of the most important measures to prevent recurrences of diabetic foot ulcerations. A Case Report.** De Windt Chloé<sup>1</sup>, Heyvaert Ilse<sup>1</sup>, Dr. De Winter Paul<sup>2</sup>, Dr. Van Acker Kristien<sup>2</sup>  
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**Introduction** The recurrence rate of diabetic foot ulcers(DFU) has a high prevalence: 70% of patients with DFU's gain a new ulcer within 3 years (1) and 60 % after a first ray amputation (2). **Statement** Secondary prevention is at least as important as are primary in patients with DFU's. By presenting this case study we, podiatrists, want to promote the use of structured podiatric secondary prevention measures in daily clinical care. Not doing it can cause a life-threatening situation, which causes also high expenses. **Case study**

In August 2011 a 46-year-old female patient, type 1 DM, presented at the outpatient clinic. She had a diabetic foot ulcer on her fifth toe that had been there for 3 years. At this time she had a "sausage toe", without wound and with destruction of bone revealed by RX. HbA1c level was 10%(86 mmol/mol). Shoe adaptations were never performed. She was prescribed oral antibiotics and a removable walker. After 6 weeks, the toe was healed. The proper education was given and she received semi- custom made shoes. She was referred to her own diabetic centre and it was asked to organize a local follow up. She did NOT get podiatric follow up, as we understood later. After one year she entered the emergency service with a hematoma/infection on the 2<sup>nd</sup> toe and a life threatening sepsis. She was monitored in the intensive care unit. The second day our diabetic foot clinic team visited her. An open amputation of the 2<sup>nd</sup> toe and metatarsal head was performed. Beside having good pulses, the wound didn't heal and a PTA, negative pressure therapy were installed followed by a surgical reconstruction. After 2 months of hospitalization, she finally went home using crutches. Two weeks later she did appeal of our emergency service again, this time with an acute charcot osteoarthropathy. MRI confirmed the Charcot combined with a stress fracture of metatarsal III. Our patient was required to wear a total contact cast during the period of 3 months. In the meantime custom made shoes were fitted. As podiatrists, we found it necessary to provide her with an orthoplasty. Follow up visits in our diabetic foot clinic showed us that compliance was very good, having also a good metabolic control. Her foot was healed. Podiatric follow up was implemented every six weeks. She received the proper podiatric education and ever since no problems have been detected so far. **Conclusion** As primary prevention is integrated in most diabetic centres in Belgium, we still need to keep in mind that podiatric follow up after the healing of a diabetic foot ulcer is even more important. The pitfall seems to exist for patients who are referred from other diabetic centres. We strongly believe that podiatrists are 'gatekeepers'. Diabetic foot centres have to rely more on this function. We like to discuss during the presentation our new thoughts of organizing secondary prevention, with integration of the patient education starting immediately during the intake period, when their alertness is the highest. **References**1.Apelqvist J, Annersten M, Eneroth M, Larsson J, Nyberg P, Thorné J. Factors related to long term outcome and recurrence of ulcers in diabetic patients with a previously healed foot ulcer. In *Abstract (Oral Pres) 5th International Symposium on the Diabetic Foot Noordwijkerhout*, The Netherlands, 2007. 2.Luca DP et al, (2003) Ulcer Recurrence Following First Ray Amputation in Diabetic Patients:A cohort prospective study, *Diabetes Care*, 26, 6, (2003), pp 1874-1878, ISSN 0149-5992