Preface

A recent article from the United Kingdom reported that guidelines on diabetic foot care are not being adhered to, resulting in a variation in the rates of potentially preventable amputations across the country. Many patients with diabetic foot lesions present late in the natural history of the condition, often because they have lost the “gift of pain” as a consequence of neuropathy. Foot ulcers and amputations result in reduced quality of life, often prolonged hospital in-patient stays, and increased morbidity and mortality. Cavanagh et al revised comparative costs of treating diabetic foot lesions in five different countries; looking at the cost burden for the individual patient, they reported that whereas treatment of a simple foot ulcer in the United States would cost the equivalent of six days of average income; a below-knee amputation in India would cost the equivalent of nearly six years of income. Thus, in this issue of the *Medical Clinics of North America*, the first few articles review the pathways to ulceration, epidemiology of foot problems, and the potential for prevention. As outlined by Jeffcoate and Margolis, problems with the definition and ascertainment of diabetes as well as differences in the measurement of amputation may partially explain variations in amputation not only between centers but also between countries.

Research in diabetic foot problems is a relatively new discipline, and the whole area has been plagued by a lack of evidence-based reports and randomized controlled trials of putative new therapies. This has partly been a consequence of the rarity of certain of the sequelae of diabetic neuropathy. Thus three reviews focus on Charcot neuroarthropathy, the commonest cause of which in the 21st century is diabetes: a recent systematic review of surgical management of Charcot neuroarthropathy confirmed that the 95 articles included were generally case reports or series classed as level 4 or 5 evidence. However, randomized controlled trials of potential therapies are extremely challenging to execute as the condition is relatively rare and no center would be able to enroll sufficient cases; multicenter trials are therefore required. In other areas such as offloading, systematic reviews and meta-analyses have been possible.

The debate over surgical versus interventional radiologic treatments of lower extremity peripheral vascular disease rages on: two articles discuss potentially different management options.
The management of diabetic foot infections continues to be debated and this is covered by Peters and Lipsky, who also discuss the recent clinical practice guidelines on this topic. The controversial topic of medical versus surgical management of osteomyelitis is discussed in two articles.

Finally, a number of new therapies and the ongoing controversy over the role of hyperbaric oxygen are debated in two reviews. During the preparation of this issue, an important article on the efficacy of hyperbaric oxygen was published and comment on this is now included in the review by Londahl.

It is hoped that this issue of Medical Clinics of North America will update the readership on these common medical problems, but most important of all, despite all the guidelines that exist, it is vital to remember as very recently pointed out in an editorial on diabetes management, to treat the patient as a whole, not only as the feet!

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REFERENCES