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By the WoundSource Editors

The definition of a diabetic wound of the lower extremity in its simplest form could be described as an open area on the lower extremity limb of anyone with diabetes. Some wound specialists would also state that pre-diabetes is still diabetes in a wound care world, so if someone with pre-diabetes develops a wound you should still treat it as if the patient had diabetes.

Defining Diabetic Foot Ulcers

In October 2001, the Centers for Medicare & Medicaid Services (CMS) put out a memorandum with a decision summary announcing coverage for foot care that would otherwise be denied as being considered routine care.¹ However, because people with diabetes are considered to have localized illness of the feet, Medicare beneficiaries with diagnosed peripheral neuropathy paired with loss of protective sensation would not be covered.¹ Why was this important? CMS goes on to explain.

"The most common diabetic complication leading to hospitalization is foot disease due to ulcerations and other lower extremity complications."¹ The amputation risk in those with diabetes is 15 to 40 times greater than in those without diabetes. At the time, even though the diabetic population comprised only 5% of the general population, more than 50% of all non-traumatic lower extremity amputations were on diabetic limbs. Diabetic amputees have a 50% chance of bilateral amputation after five years, and their survival rate at year three is only 50%. After five years, the survival rate is approximately 40%.¹

[How much do you know about managing diabetic foot ulcers? Take our 10-question quiz to find out! Click here.](#) [7]

In this nearly 20-year-old memorandum, CMS points out that individuals with diabetes are at risk of lower extremity amputations as a result of several factors, including the following: peripheral neuropathy; peripheral vascular disease; foot lesions such as ulcers, deformities, infections, and nail disorders; and of course, a prior amputation. According to the American Academy of Family Physicians, the most common sites of diabetic ulcer development are the pad of the foot and the heel.² This article goes on to state that peripheral arterial occlusive disease is four times more prevalent in people with diabetes than in those without diabetes. Even though we have had a decent understanding of these conditions for a long time, health care as a whole still struggles with diagnosing and understanding proper treatment pathways.

Cleveland Clinic on Diabetic Foot Ulcers

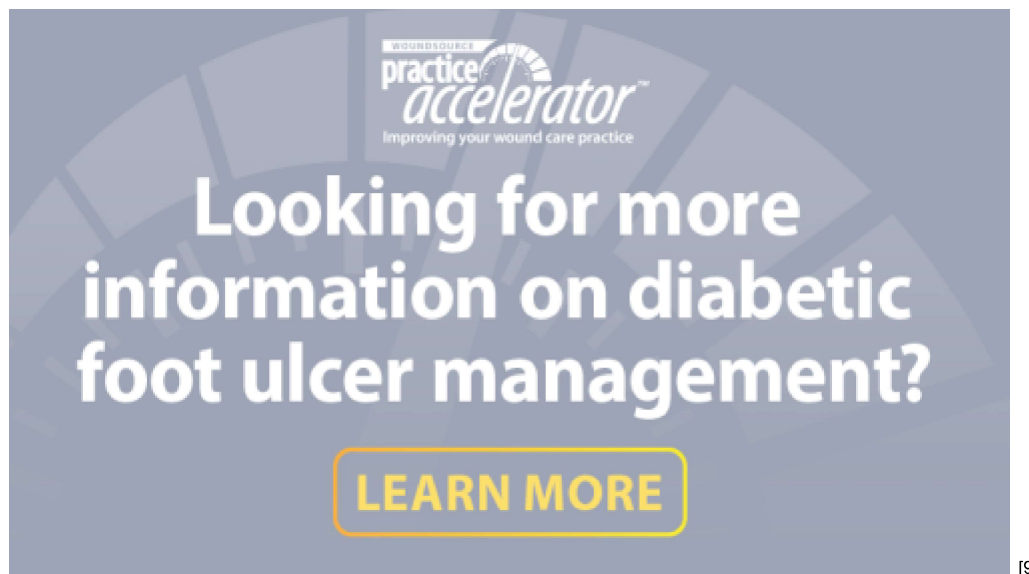
The Cleveland Clinic [8] does a great job at outlining no fewer than 15 medical conditions that can cause ulcers in the lower extremity. They relay that diabetic ulcers can occur anywhere on the foot but are typically located at increased pressure points and usually occur in patients who have neuropathy and peripheral arterial disease as well. On their website, they remind us that arterial ulcers can occur in the same places as diabetic ulcers, including on the heel, tips of toes, between the toes, and other areas where bones may be located, such as the ankle. Diabetic ulcers almost invariably are multifactorial and are rarely arise JUST from diabetes.

Differential Diagnosis of Diabetic Foot Ulcers

The exact incidence of diabetic heel ulcers is not known, but the incidence of pressure heel ulcers in patients with and without diabetes ranges from 19% to 32%.³ Arterial wounds can occur on the heel as well. These conditions can overlap and intertwine and often co-exist. To simplify the quest to determine etiology, consider this: If a patient has an open wound of the lower extremity and diabetes paired with assessed and documented neuropathy (Semmes Weinstein monofilament test or other), then it is almost certainly a diabetic wound of the lower extremity, but we can't stop there. Vascular studies should be done to determine whether any blockage exists. If ischemia is moderate to severe based on studies, then the wound would be primarily ischemic, with diabetes as a secondary wound classification. However, when determining whether the wound has pressure as a component, your strongest asset is a visual examination. If you see pressure occurring, it is pressure. This does not mean walking into the room and finding an ulcer over a bone and then declaring it a pressure ulcer. We know multiple wound etiologies can occur over bony prominences. But ask yourself whether you saw pressure occurring. Did you put on the splint and visualize where the splint falls versus where the wound is? Did you place the patient in their chair or wheelchair and look to see where the wound is versus what could be causing pressure? Without a thorough examination looking for causation, wounds can look the same.

Conclusion

The risk of amputation in patients with diabetic wounds of the lower extremity is high, and careful diagnostic examinations and studies are needed to ascertain the cause of these ulcers so that appropriate treatment can be instituted.



References

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