

Global expert dialogue on diabetic foot ulcer care: driving urgency, innovation and collaboration

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ABSTRACT

Diabetic foot ulcers (DFUs) have devastating patient and health economic implications, with high infection rates due to unsatisfactory outcomes from current treatment options. A global roundtable of eight DFU experts was held in London in December 2024 to explore pathways for better DFU treatment. This meeting report highlights several key calls to action raised by the panel. Firstly, moving the mindset from passive care of DFUs to proactive treatment, while highlighting new patient-centred metrics. Secondly, early and targeted interventions to reduce infection risk. Thirdly, unification of DFU guidelines for improved practicality. Fourthly, relentless focus on education of patients and healthcare professionals. Finally, global collaboration on key matters, such as clinical research and refinement of guidelines and definitions. A new multimodal, nitric oxide-generating dressing was discussed as a potential option for improving local infection and healing outcomes. The panel is committed to publishing outputs of further roundtables with the goal of improving outcomes for DFU patients.

Keywords challenges, diabetic foot ulcer, infection, innovation, multimodal, nitric oxide.

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KEY MESSAGES

- A report of the first discussion of a panel of global experts on the urgent need to improve outcomes for DFU patients
- The need for innovations in DFU treatment for better infection and healing outcomes was highlighted
- Proactivity and urgency of education, including new patient metrics, and collaboration on the simplicity of guidelines and terminology, were calls to action

INTRODUCTION

Diabetic foot ulcers (DFUs) remain a devastating complication of diabetes, with unacceptably high rates of infection, hospitalisation and lower-limb amputation. Despite existing clinical guidance and a growing arsenal of treatment options, outcomes remain poor for far too many patients. To address this urgent issue, a global advisory panel of leading experts in DFU care was convened. Held in December 2024 in London, the inaugural meeting brought together eight leading international experts across diabetes care, wound care, infection, surgery and podiatry with a shared mission: to challenge the status quo and define a new path forward in DFU treatment. (The travel and consultancy was funded by Convatec).

This roundtable marked the beginning of a multi-stage dialogue to address persistent clinical gaps, refine best practices and shape the future of DFU treatment, aimed at improving outcomes. Over the course of two days, the panel shared deep clinical insights and explored strategic areas for improvement, including early intervention, diagnostic challenges, individualised and dynamic care strategies, emerging innovations and a renewed focus on education, guidance and collaboration.

The group also explored the anticipated launch of a novel multimodal, nitric oxide-generating dressing, ConvaNiox™ (Convatec, UK), highlighting its potential role in transforming the management of DFUs.¹

This report presents the key takeaways from that first meeting and signals a call to action: to elevate the urgency of DFU care and build a shared roadmap for improving outcomes through evidence-based innovation, education and collaboration.

THE BURDEN OF DIABETIC FOOT ULCERS AND THE UNMET CLINICAL NEED

It is estimated that DFUs affect 40–60 million people globally at any given time (Figure 1).² They are associated with devastating consequences: severe infection, extended hospital stays, diminished quality of life, and a high risk of

lower limb amputation (Figure 1).^{3,4} The financial burden is staggering, with costs directly associated with DFUs in the US alone an estimated \$9–13 billion per year,⁵ while in England expenditure on DFUs exceeds spending on the three most common cancers combined.⁶

More concerning, however, is the stagnation in patient outcomes. Infections—the principal cause of damage to diabetic feet—occur in 50–60% of DFUs.³ Of these, approximately 20% of moderate or severe diabetic foot infections result in lower extremity amputations.³ The 5-year mortality rate following major amputation approaches 40% (Figure 1),⁷ surpassing that of most cancers.⁸

Despite advances in skin care and wound management, healing rates for DFUs remain unacceptably low, highlighting a clear unmet need for more effective treatments. Guest et al (2020)⁹ reported healing rates as low as 40% at one

year (Figure 1), while a recent meta-analysis by Coye et al (2025)¹⁰ found a pooled healing rate of just 33.15% over a 12 to 24-week period in patients receiving standard care (Figure 1), with an average healing time of 50 days (SD: 31.10 days). These data underscore the persistent challenge for healthcare professionals and the urgent need for improved therapeutic options to better support this high-risk population.

During the meeting, panellists acknowledged that despite clinical awareness, DFUs continue to be misdiagnosed, under-treated, or referred too late. They identified infection and ischemia as the two most common and challenging barriers to healing. However, many ulcers are managed with an overly generic approach, often without a clear assessment of the dominant wound pathology. Compounding this is the confusing landscape of DFU guidelines, which can be complex, fragmented, or poorly adapted to real-world settings.

Diabetic Foot Ulcers: The Silent Epidemic Behind Diabetes



537
million people
worldwide
have **diabetes**²



19-34%
of people
with diabetes
will develop a **DFU**
in their lifetime²



Only **33%** of DFUs
receiving standard of care **heal**
over **12-24 week period**⁵
increasing to 40% at 1-year⁶



40% of patients experience **DFU**
recurrence within 1 year of healing
(60% within 3 years, 65% within 5 years)⁴



50-60%
of DFUs
become **infected**³

20%
of people
who develop
a DFU require
amputation²



40%
of people will **die**
within **5 years** of their
first DFU diagnosis⁹

Figure 1. Diabetic foot ulcers: the silent epidemic behind diabetes.

The group emphasised that “disconnects between guideline theory and clinical reality” contribute to variable care quality and worse outcomes.^{11,12} Furthermore, patient-related factors—such as poor glycaemic control, comorbidities, and inconsistent adherence—further complicate management and underscore the need for a proactive, patient-centred approach and innovative therapeutic options.

KEY DISCUSSION POINTS AND FUTURE FOCUS AREAS

1. From wound care to proactive and holistic patient management

One of the meeting’s most powerful takeaways was the shift in mindset proposed by several panellists: to stop thinking about DFU management as simply wound care and start treating it as systemic disease management. Panellists stressed that DFUs are not static—they evolve with time, patient health and environmental factors. Effective treatment must be adaptable, moving beyond a narrow focus on wound care toward a more proactive and holistic patient management approach. This means prioritising early diagnosis, ulcer-free days, hospital-free days, and preserved mobility as the true metrics of success.

2. Earlier, smarter intervention

There was strong consensus that waiting to escalate care—especially in the context of infection—is counterproductive. Delayed referrals, misdiagnoses and over-reliance on visual cues often translate to missed opportunities for early intervention. They challenged the traditional notion of waiting four weeks before escalating treatment,¹³ asking, “Why wait?” when early advanced intervention could change outcomes. Experts advocated for tools and protocols that support early, targeted action, especially in wounds at risk of infection.

3. Simplifying and unifying guidelines

Despite existing clinical guidelines, real-world implementation remains inconsistent. Barriers include diagnostic ambiguity, unclear infection indicators, underdiagnosis of ischemia, and fragmented care pathways. Panellists described current DFU guidelines as “dense,” “confusing,” and often impractical for frontline clinicians. There is a pressing need for simplified, unified frameworks that help clinicians rapidly identify the dominant pathology, assess risk and select appropriate therapies without ambiguity. More intuitive tools and education are needed.

4. Bridging the knowledge gap

Patient education and health care professional (HCP) training emerged as high priority focus areas. Panellists highlighted that even advanced therapies are underutilised, largely due to lack of understanding or systemic barriers. Patient compliance remains a major barrier, particularly among those with multiple comorbidities.¹⁴ Education must be enhanced not only for HCPs but for patients and caregivers, fostering better understanding, ownership, and engagement in their care. Improving communication, addressing misconceptions and increasing knowledge transfer were deemed essential to changing the status quo.

5. Shaping the research agenda

Panellists called for greater investment in real-world evidence, randomised controlled trials and subgroup analysis to

better define which patients benefit most from emerging technologies. Five key themes emerged from panellist discussion with widespread interest in collaborating on:

- i Real-world evidence generation
- ii Guideline development
- iii Providing clearer operational definitions of infection and infection risk
- iv Determining the subset of neuroischemic DFUs with potential for healing
- v Exploring outcome measures that matter most to patients

EMERGING INNOVATION: A NEW TECHNOLOGY FOR DFU MANAGEMENT

The panel had an in-depth discussion about a new multimodal, nitric oxide-generating dressing, (ConvaNiox™ by Convatec, UK), which generated significant clinical interest. Designed to address the persistent issue of infection, colonisation and stagnation/recalcitrance in DFUs, it combines multiple mechanisms of action that support host healing¹ and may reduce dependence on systemic antibiotics.¹⁵ Panellists recognised its potential to play a pivotal role in early-stage management, particularly for wounds at risk of infection or with suspected biofilm.

Two clinical use scenarios were explored:

- **Scenario 1:** Using the multimodal dressing as standard of care from initial assessment.
- **Scenario 2:** Initiating use of the multimodal dressing only after four weeks of inadequate progress.

After considering the RCT data,¹ experts were unanimous in preferring Scenario 1, arguing that proactive infection control could improve healing trajectories and potentially reduce the need for systemic antibiotics.

Panellists emphasised the importance of clear communication on the multimodal dressing’s mechanisms of action, robust clinical data and a defined role within treatment algorithms. The multimodal dressing’s alignment with growing concerns around antimicrobial resistance was also seen as timely and strategically important.

CONCLUSION AND NEXT STEPS

This global advisory panel meeting delivered more than a forum for discussion—insights provide a roadmap for ongoing collaboration and change. The roundtable discussion underscored the need for:

- Earlier, more proactive intervention
- Evidence-driven personalisation of care
- Better education and integration of guidelines
- Improved collaboration between clinicians, researchers and industry

The sponsor, Convatec, UK, in collaboration with expert panels, is engaged in efforts to advance DFU care. Current initiatives are directed toward supporting improved healing, reducing infection and amputation rates, and enhancing outcomes for people living with diabetes. The expert panel will continue its work through 2025, providing insights to inform clinical practice, guide research priorities and refine the application

of technologies, such as multimodal wound dressings, such as ConvaNiox™. These activities aim to contribute to the broader goal of improving DFU management and patient care worldwide.

CONFLICT OF INTEREST

All authors serve as consultants to Convatec.

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