Editorial

Diabetes- when a wound becomes an amputation

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It is our pleasure to present this edition of the *Wound Practice and Research Journal*. This particular edition, which focused on the problem of wound healing in diabetes, was themed to coincide with Asia Pacific Conference on the Diabetic Limb. This conference, held at Monash University, Melbourne, brought together leading figures from Australia and the Asia Pacific region to broaden knowledge and understanding of the disease itself and its complications and, in particular, the management of the diabetic with a wound. The conference included presentations from a broad range of specialists and gave participants the opportunity to attend three workshops on assessment and offloading.

The numbers of persons with a diagnosis of diabetes or a predisposition towards diabetes is increasing and this, combined with an ageing population, has amplified the numbers of persons with chronic, non-healing wounds. This increase in numbers as well as the substantial costs both to the individual and society has led to considerable efforts directed towards the prevention of the development of ulcers. Additionally, there has been a strong focus on the identification of those at risk of poor outcomes and an effort to improve and evaluate treatments. The National Diabetes Audit has reported that in diabetic persons the most common form of ulceration is a foot ulcer, occurring in 2.1% of the population; for this reason the focus of many of the articles in this issue is the diabetic foot. These articles have used locally gathered data to examine specific questions including: investigations relating to healing, evaluation of a service model to determine whether it has quantifiable benefit and the assessment of risk evaluation tools. The study by Veldhoen et al. investigated the utility of negative pressure therapy to assist in the healing of post-surgical diabetic wounds. The article by Nube *et al.* discusses how to evaluate the effectiveness of provision of a specialised foot service, using the high-risk foot service at RPA Hospital as a test case. The clinical utility of the new Society for Vascular Surgery (SVS) Lower Limb Threatened Classification, termed the WIfI classification, is also investigated. This WIfI classification includes a grading system for ischaemia and will deliver important information regarding risk for amputation. It may also aid in determining the benefit derived from revascularisation. The systematic review and meta-analysis by Sonter et al. provides potentially valuable information regarding a consensus on the cutoff values for toe systolic blood pressure (TSBP) and toe brachial index (TBI) and prediction of the need for amputation. It is very sobering to note that of the 42 studies identified, only 19 studies were accessible in full text and 10 met the criteria for this analysis. This lack of publication is disappointing and would suggest that at least 50% of studies are not reaching the public arena.

As discussed by Shaw in an excellent review regarding the progress made in the reduction of amputations, a critical component to enable better care, and better outcomes, is the collection of data. Data collection is, as we all know, difficult in an environment of increasing demand and staff shortages. This is further compounded when attempting to analyse data across centres where there are differences in reporting requirements and levels and differences in coding across different health care providers. It is possible that some of these difficulties could be overcome by the provision of specialised, high-risk services, which by treating specific types of patients would be more focused and better able to collect, analyse and report data. A unified and national approach to reporting and coding of data would also help. Whatever the approach, it is clear, particularly in this high-risk group, that more efforts are required to develop treatments and assess the outcomes of wound care delivery.

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