زخم دیابتی

IWGDF Infection Guideline

دکتر سعیدرضا جمالی مقدم

متخصص بیماری های عفونی

- Diagnose a soft tissue diabetic foot infection clinically, based on the presence of local or systemic signs and symptoms of inflammation.

- In a person with diabetes and suspected osteomyelitis of the foot, we recommend using a combination of the probe-to-bone test, the ESR (or C-reactive protein and/or procalcitonin), and plain X-rays as the initial studies to diagnose osteomyelitis.

- In a person with diabetes and suspected osteomyelitis of the foot, if a plain X-ray and clinical and laboratory findings are most compatible with osteomyelitis, we recommend no further imaging of the foot to establish the diagnosis.

- If the diagnosis of osteomyelitis remains in doubt, consider ordering an advanced imaging study

- collect a sample of bone (percutaneously or surgically) to culture clinically relevant bone microorganisms and for histopathology (if possible)

- Do not use molecular microbiology techniques for the first-line identification of pathogens from samples in a patient with a diabetic foot infection

- Treat a person with a diabetic foot infection with an antibiotic agent include: penicillins , cephalosporins , carbapenems , metronidazole (in combination with other antibiotic[s]), clindamycin, linezolid, daptomycin , fluoroquinolones, or vancomycin, but not tigecycline . (Strong; High)

- Administer antibiotic therapy initially by the parenteral route to any patient with a severe diabetic foot infection. Switch to oral therapy if the patient is clinically improving, has no contraindications to oral therapy and if there is an appropriate oral agent available.

- We suggest not using any currently available topical antimicrobial agent for treating a mild diabetic foot infection

- Administer antibiotic therapy to a patient with a skin or soft tissue diabetic foot infection for a duration of 1 to 2 weeks and up to 3-4 weeks, if the infection is improving but is extensive, is resolving slower than expected, or if the patient has severe peripheral artery disease.

- If evidence of infection has not resolved after 4 weeks of apparently appropriate therapy, reevaluate the patient and reconsider the need for further diagnostic studies or alternative treatments.

- Do not treat clinically uninfected foot ulcers with systemic or local antibiotic therapy

- Treat diabetic foot osteomyelitis with antibiotic therapy for no longer than 6 weeks. If the infection does not clinically improve within the first 2-4 weeks, reconsider the need for collecting a bone specimen for culture, undertaking surgical resection, or selecting an alternative antibiotic regimen.

- In a patient with diabetes and uncomplicated forefoot osteomyelitis, for whom there is no other indication for surgical treatment, consider treating with antibiotic therapy without surgical resection of bone.

- For a diabetic foot infection do not use hyperbaric oxygen therapy or topical oxygen therapy as an adjunctive treatment if the only indication is specifically for treating the infection.

- Consider the use of systemic hyperbaric oxygen therapy as an adjunctive treatment in non-healing ischaemic diabetic foot ulcers despite best standard of care

- We suggest not using topical oxygen therapy as a primary or adjunctive intervention in diabetic foot ulcers including those that are difficult to heal

To specifically address infection in a diabetic foot ulcer:

do not use adjunctive granulocyte colony stimulating factor treatment and,

do not use :

topical antiseptics,

silver preparations,

honey,

bacteriophage therapy, or

negative-pressure wound therapy

- Do not use dressings/applications containing surface antimicrobial agents with the sole aim of accelerating the healing of an ulcer

- Consider the use of the sucrose-octasulfate impregnated dressing as an adjunctive treatment, in addition to best standard of care, in non-infected, neuro-ischaemic diabetic foot ulcers that are difficult to heal

- Consider the use of negative pressure wound therapy to reduce wound size, in addition to best standard of care, in patients with diabetes and a post-operative (surgical) wound on the foot

- We suggest not using negative pressure wound therapy in preference to best standard of care in non-surgical diabetic foot ulcers

- Consider the use of placental derived products as an adjunctive treatment, in addition to best standard of care, when the latter alone has failed to reduce the size of the wound
- We suggest not using :

growth factors , autologous platelet gels , bioengineered skin products , topical carbon dioxide and nitric oxide, in preference to best standard of care.

- Consider the use of autologous combined leucocyte, platelet and fibrin as an adjunctive treatment, in addition to best standard of care, in non-infected diabetic foot ulcers that are difficult to heal.

- Do not use agents reported to have an effect on wound healing through alteration of the physical environment including through the use of electricity, magnetism, ultrasound and shockwaves, in preference to best standard of care.
- Do not use interventions aimed at correcting the nutritional status (including supplementation of protein, vitamins and trace elements, pharmacotherapy with agents promoting angiogenesis) of patients with a diabetic foot ulcer, with the aim of improving healing, in preference to best standard of care.

تشکر از حسن نظر شما