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THE COMPLICATIONS OF DIABETIC ISCHAEMIA

Mark Welch

Consultant Vascular Surgeon

MIMS Nurse Workshop, April 29, 2015



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Gary Mabbutt left with 30inch scar after five hour operation to save his leg when his diabetes caused clogged artery

- **Spurs legend woke up in middle of the night to find his leg was cold**
- **Mabbutt diagnosed with diabetes at 17 but complications had developed**
- **He required the main artery to be replaced and almost lost his left leg**
- **The ex-Spurs star wants to raise awareness of dangers relating to diabetes**

By JACK CRONE FOR MAILONLINE

PUBLISHED: 01:59, 7 April 2015 | UPDATED: 10:32, 7 April 2015



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Gary Mabbutt has spoken for the first time about how he was left with a 30 inch scar following a five hour operation to save his leg.

The ex-Tottenham and England star, 53, was rushed to hospital after waking up at 1am to find that the leg had gone cold back in 2013.

Mabbutt's diabetes had led to a clogged artery in the limb and doctors warned him it was 'touch and go' on whether it would have to be amputated.



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Gary Mabbutt has been left with a 30inch scar on his left leg after his diabetes caused an artery to be clogged

He was treated at King's College Hospital in south east London, undergoing an emergency five-hour operation.

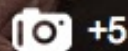
Surgeons were required to replace the main artery in his left leg with a vein and needed 112 staples to seal the horrific wound.

Mabbutt, who was diagnosed with Type 1 diabetes at 17, will not be able to play football again, leaving his dream of becoming a manager in tatters.

As he is unable to train with players on the pitch, he has been forced to turn down roles in coaching.



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Surgeons were required to replace the main artery in his left leg with a vein and needed 112 staples to seal it

AVENUES OF ASSESSMENT & REFERRAL

- ◆ General Practitioner
 - ◆ GP Practice Nurse
 - ◆ Podiatrist

 - ◆ Other Hospital Specialist
 - ◆ Emergency Department
- 
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PURPOSE OF SPECIALIST REFERRAL

- ◆ To obtain definitive diagnosis
 - ◆ To determine appropriate management
 - ◆ To ensure quality opinion for patient and GP
- 

WHO TO REFER?

- ◆ New onset of significant symptoms
- ◆ Progression of symptoms
- ◆ Diagnostic doubt
- ◆ Patient anxiety
- ◆ Abnormal clinical signs
 - Foot lesions
 - Poor Doppler pressures

MODE OF INITIAL ASSESSMENT

- ◆ History
 - ◆ Examination
 - ◆ Hand held Doppler ultrasound
- 
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ISCHAEMIA SEVERITY?

- ◆ Degree of disability
- ◆ Quality of life
- ◆ Worrying clinical signs
- ◆ Poor Doppler pressure / ABPI

MANAGEMENT


- ◆ Non – Interventional
- ◆ Interventional
- ◆ REMEMBER: 3 – 4 x RISK OF DEATH COMPARED WITH GENERAL POPULATION

NON INTERVENTIONAL MANAGEMENT

- ◆ Counsel patient
 - ◆ Correct risk factors
 - ◆ Treat symptoms
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CORRECT RISK FACTORS

- ◆ Stop smoking
 - ◆ Diet
 - ◆ Aggressive BP control
 - ◆ Statins

 - ◆ Better control of diabetes
- 
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ANTI-PLATELET AGENTS

- ◆ Aspirin
- ◆ Clopidogrel

EXERCISE

- ◆ STRUCTURED EXERCISE PROGRAMMES

SYMPTOMATIC TREATMENT

- ◆ Drugs
 - Peripheral vasodilators (NAFTIDOFURYL)
- ◆ Invasive intervention

INTERVENTIONAL MANAGEMENT


- ◆ Disabling claudication
- ◆ Critical ischaemia
 - REST PAIN
 - ULCERATION
 - GANGRENE

WHERE IS THE DISEASE?

- ◆ Colourflow DUPLEX Ultrasound
- ◆ Magnetic resonance angiography
- ◆ DETERMINES ANGIOPLASTY SUITABILITY

CRITICAL LIMB ISCHAEMIA

- ◆ Rest pain
 - ◆ Ulceration
 - ◆ Gangrene

 - ◆ Infection
- 
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CRITICAL LIMB ISCHAEMIA


- ◆ Higher incidence in diabetics
 - ◆ Incidence increasing
 - ◆ Large financial burden
 - ◆ Aggressive policy reduces amputation rate
- 

CRITICAL ISCHAEMIA IN THE DIABETIC

- ◆ Neuropathy
 - ◆ Ischaemia
 - ◆ Infection
- 

MANAGEMENT OF CRITICAL ISCHAEMIA IN DIABETES (1)

- ◆ Drainage of abscesses
 - ◆ Digital / forefoot amputation
 - ◆ Debridement

 - ◆ Antibiotics
 - ◆ Glycaemic control
- 

MANAGEMENT OF CRITICAL ISCHAEMIA IN DIABETICS (2)

- ◆ Aggressive Revascularisation

REVASCULARISATION

- ◆ Endovascular
 - Balloon angioplasty (DEB)
 - Stents
 - Better for shorter lesions
 - More durable patency in iliac arteries
- ◆ Surgery

THE FUTURE FOR TREATMENT

- ◆ Drugs
 - ◆ Improved angioplasty balloon & stent technology
 - ◆ Stent grafts
- 
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CASE 1

- ◆ WL; 81 male
- ◆ Admitted from clinic MDGH; dry gangrene right 2nd & 3rd toes
- ◆ Type 2 diabetes
- ◆ No pulses below CFA; duplex shows SFA occlusion



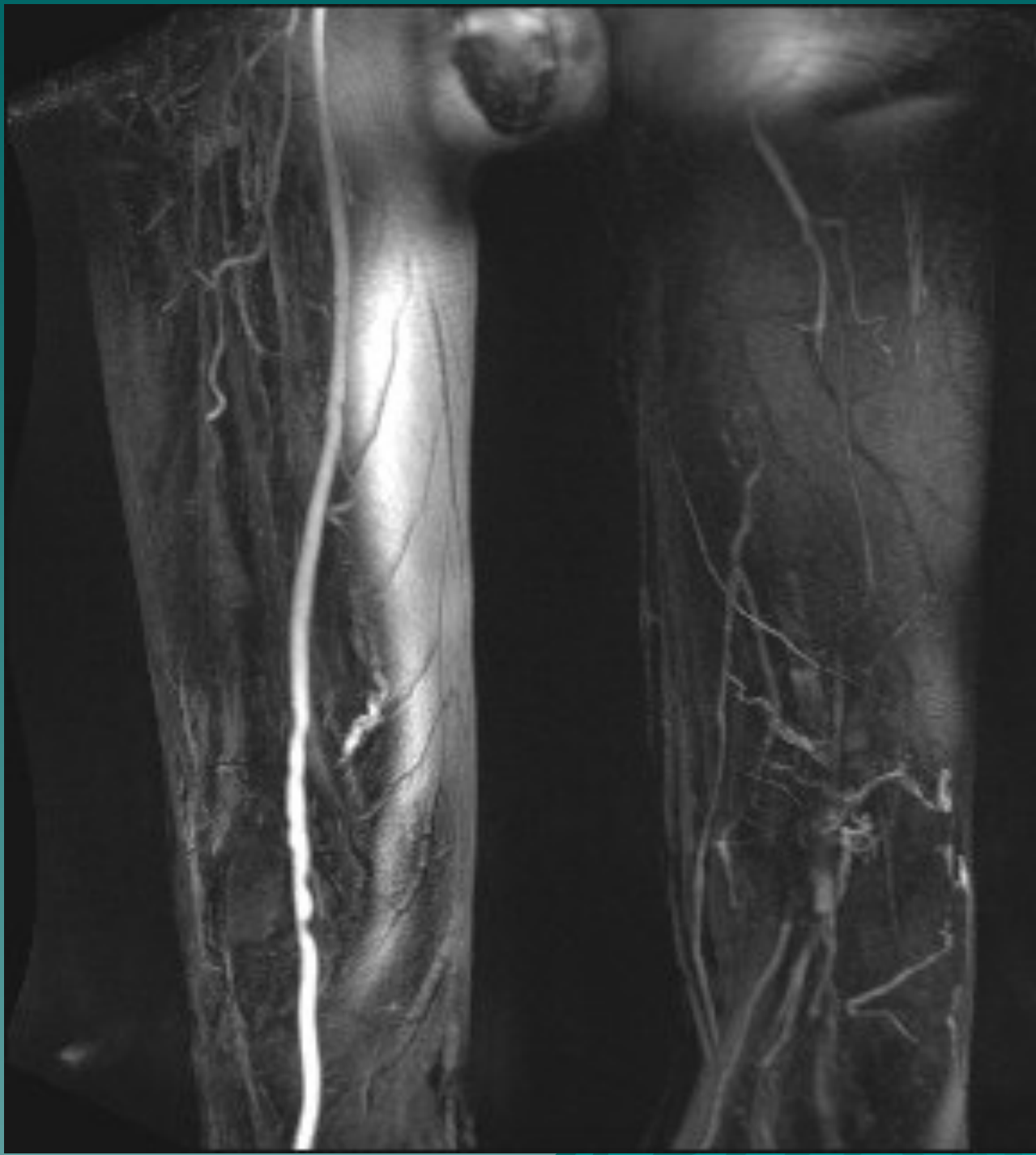




CASE 2

- ◆ IH; 59 male
- ◆ Admitted from A&E with 2 weeks worsening rest pain & ulceration toes left foot, esp big toe
- ◆ Type 2 diabetes; smoker; prev CVA
- ◆ Palpable CFA pulse; duplex showed occluded SFA, pop & tibials





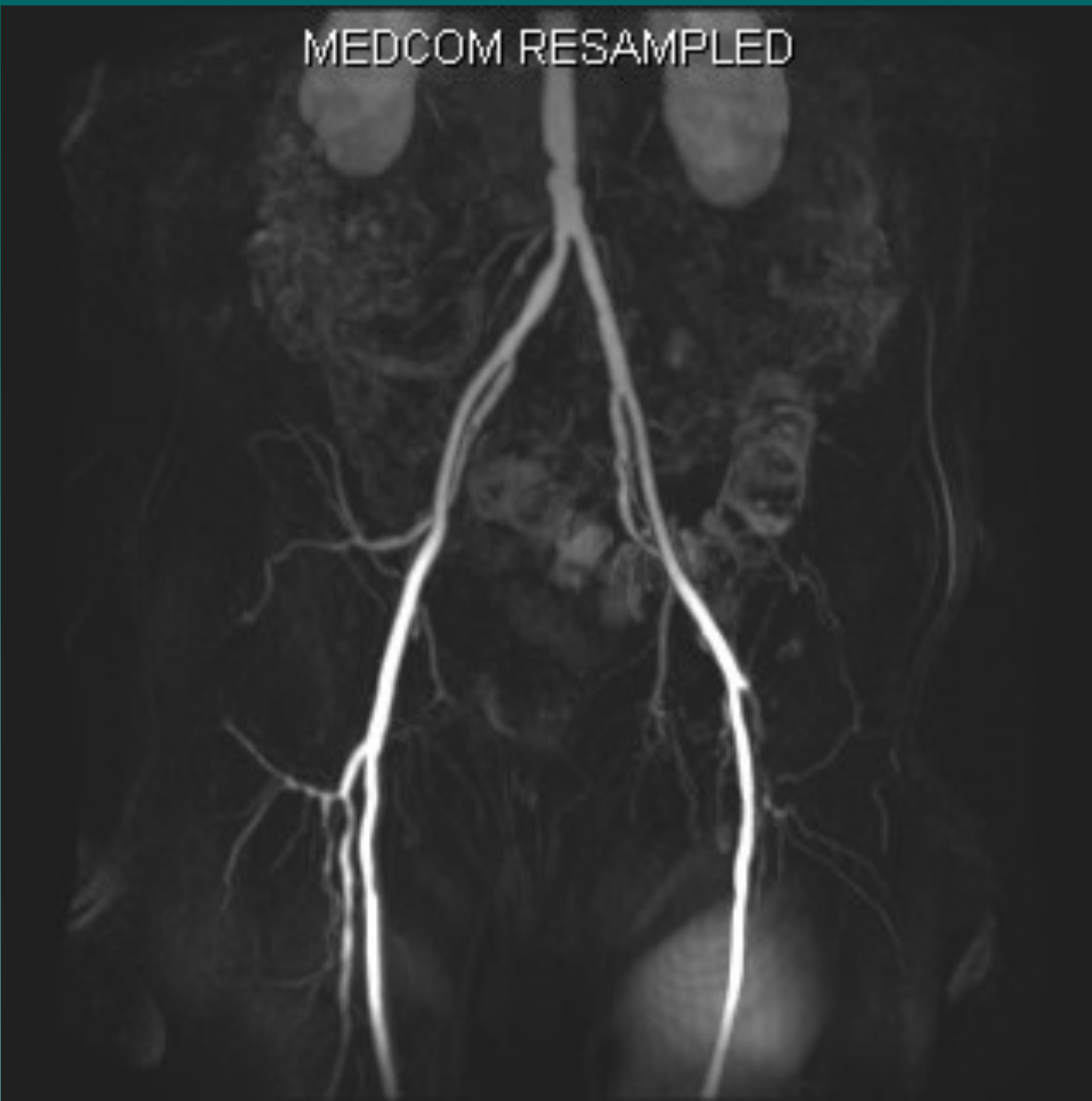
MEDCOM RESAMPLED



CASE 3

- ◆ JK; 79 male
- ◆ Admitted from A&E with 3 weeks rest pain left little toe; long standing claudication
- ◆ Type 2 diabetes
- ◆ Blue little toe; palpable groin pulse; duplex showed distal disease

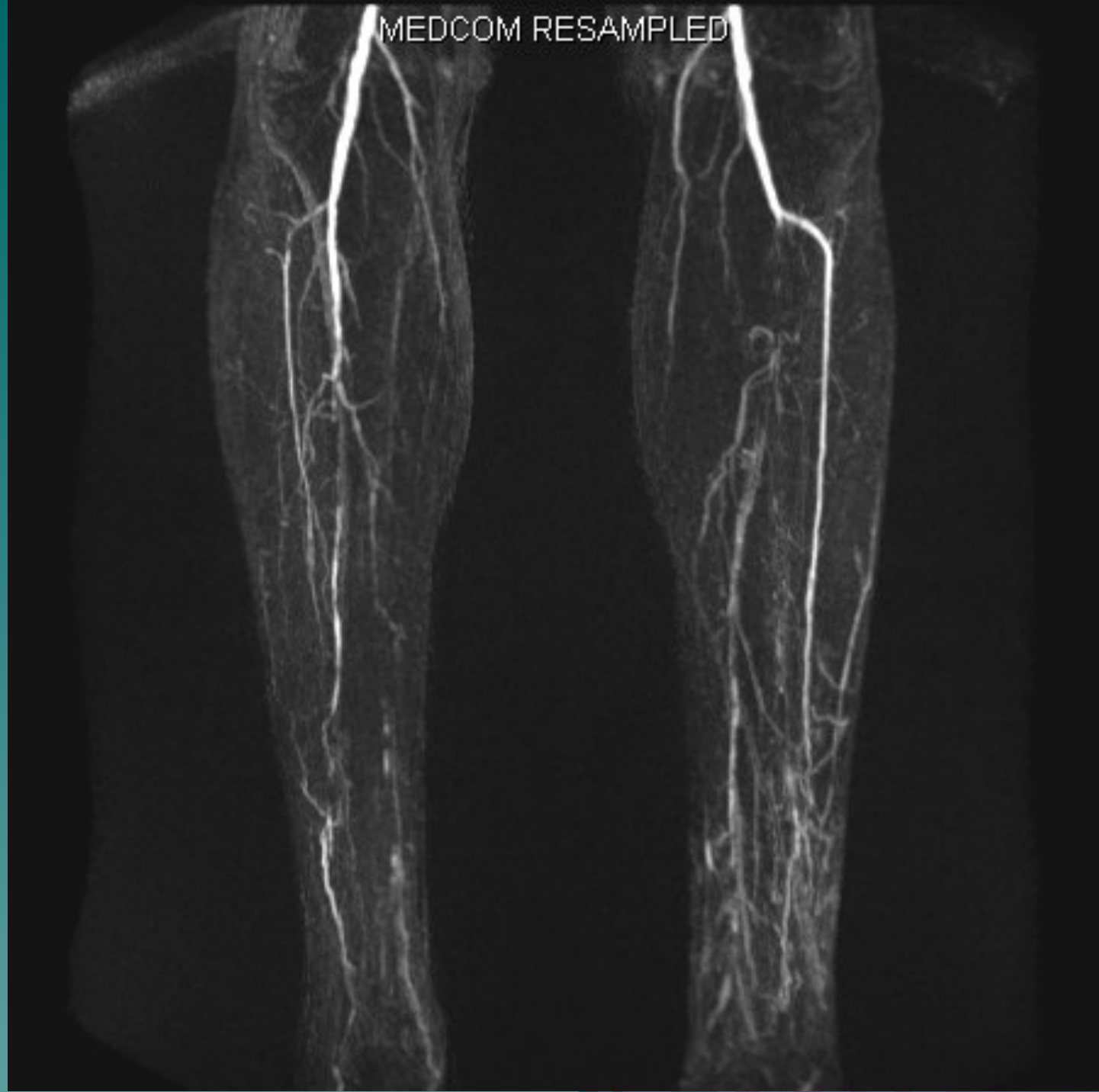
MEDCOM RESAMPLED




MEDCOM RESAMPLED



MEDCOM RESAMPLED



CASE 4

- ◆ SB; 56 female
 - ◆ Referred from orthopaedics MDGH
 - ◆ Diabetic foot ulceration
 - ◆ Type 2 diabetes
- 
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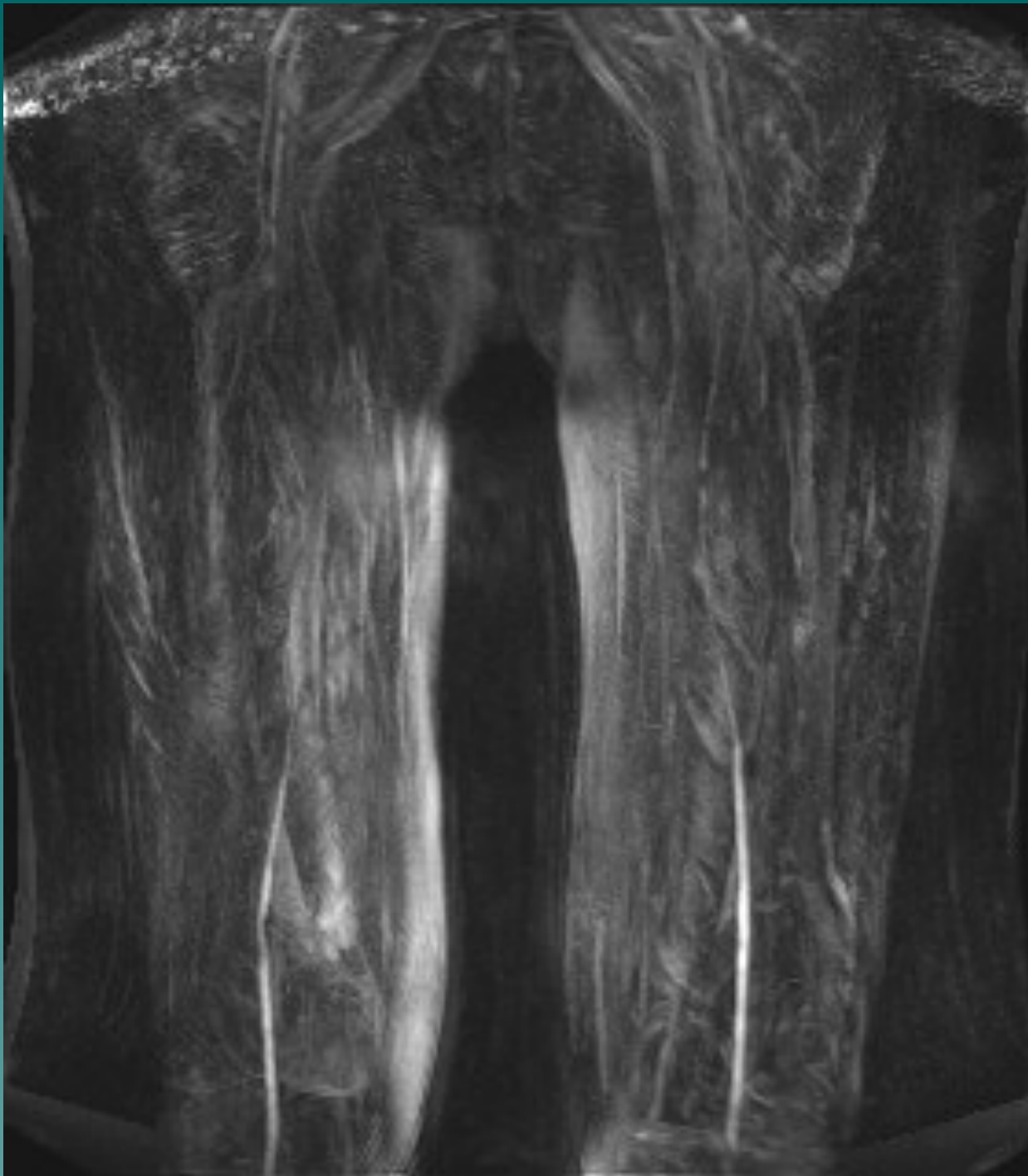




CASE 5

- ◆ CA; 81 male
- ◆ Admitted from clinic; gangrenous ulceration right foot
- ◆ Type 2 diabetes
- ◆ No pulses; multisegment disease on duplex






MEDCOM RESAMPLED



SUMMARY

- ◆ Thorough clinical assessment
 - ◆ Strict risk factor management
 - ◆ Strict control of diabetes
 - ◆ Conservative treatment of claudicants
 - ◆ Urgent referral for critical ischaemia
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URGENT REFERRAL OF DIABETICS TO VASCULAR SURGERY

- ◆ Criteria:
 - Non healing ulcer / absent pedal pulses
 - Pain at rest
 - Gangrene

HOW TO REFER

- ◆ Phone vascular registrar on call
- ◆ Fax Vascular Department
 - 0161 291 6644

THE FUTURE FOR ASSESSMENT

- ◆ Joint clinics
 - DIABETOLOGIST
 - VASCULAR SURGEON
- Simplify referral pathways

THE IDEAL UNIT

- ◆ Diabetologist
- ◆ Vascular Surgeon
- ◆ Podiatrist
- ◆ Orthopaedic surgeon
- ◆ Plastic surgeon