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IWGDF Guidelines

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Guidelines on interventions to enhance healing of foot ulcers in people with diabetes

IWGDF 2023 update

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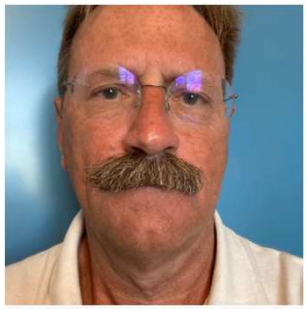

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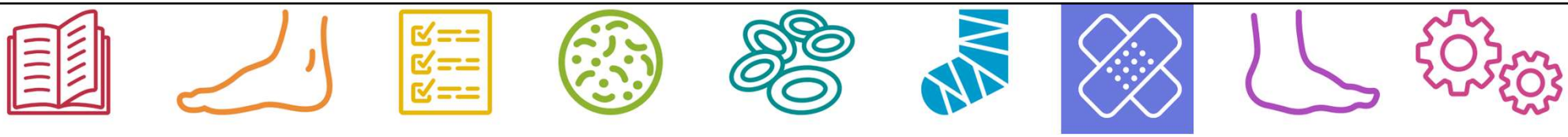
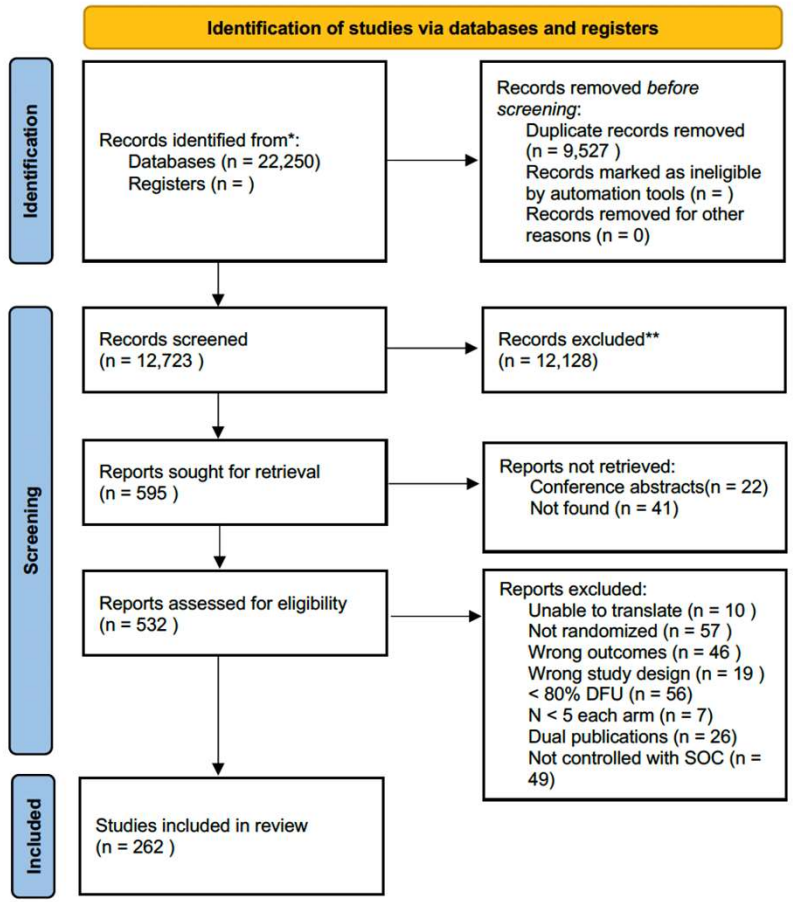
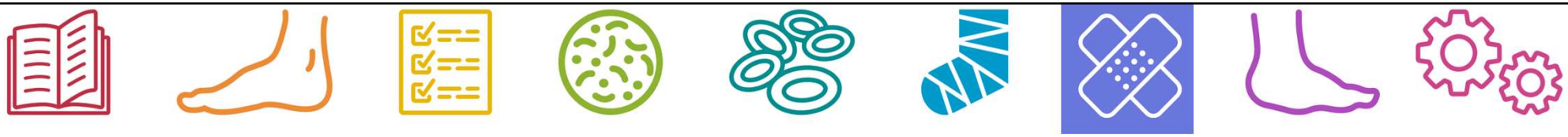


What's new compared to the 2019 wound healing guideline

- We performed an entirely new systematic review of wound healing interventions and re-evaluated previous interventions in line with newest benchmarking and risk of bias assessments.
- We only evaluated RCTs to ensure only evidence at the highest level was included.
- We increased the number of outcomes critical to decision making; wound healing, reduction in ulcer area, time to healing, sustained healing, amputation (major/minor), resource utilisation, quality of life, maintenance of function/ability to perform activities of daily living, new infection and mortality.
- We added new clinical questions on behavioural, educational and pharmacological interventions.

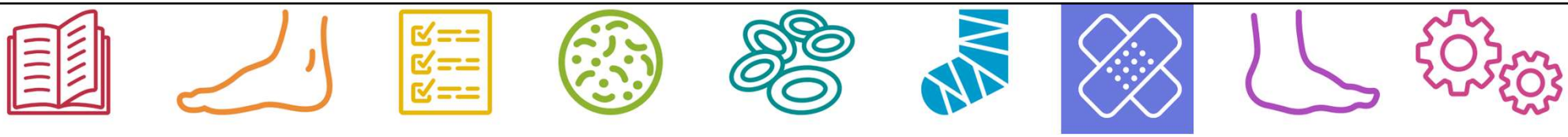
PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only





Recategorisation of some interventions:

1. Debridement:
2. Dressings and topical applications:
3. Oxygen and other gases:
4. Physical alteration of wound bed:
5. Skin substitutes:
6. Autogolous products, growth factors, and other cellular therapies:
7. Pharmacological:
8. Negative pressure wound therapy:
9. Educational, psychological and behavioural:

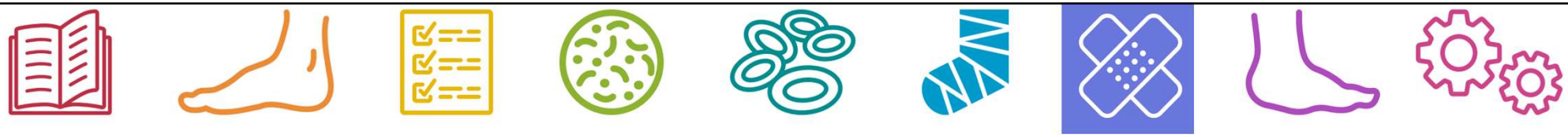


Key recommendations: new, different and positive

2. Do not routinely use enzymatic debridement as opposed to standard of care (i.e. sharp debridement) to improve wound healing outcomes in people with diabetes and a foot ulcer. (Strong; Low).

2a. In specific situations where the availability of sharp debridement may be limited by access to resources and/ or availability of skilled personnel, consider using enzymatic debridement. (Conditional; Low).

9. Consider the use of the sucrose-octasulfate impregnated dressing as an adjunctive treatment, in addition to the best standard of care, in non-infected, neuro-ischaemic diabetes-related foot ulcers which have had insufficient change in ulcer area with best standard of care including appropriate offloading for at least 2 weeks (Conditional; Moderate).



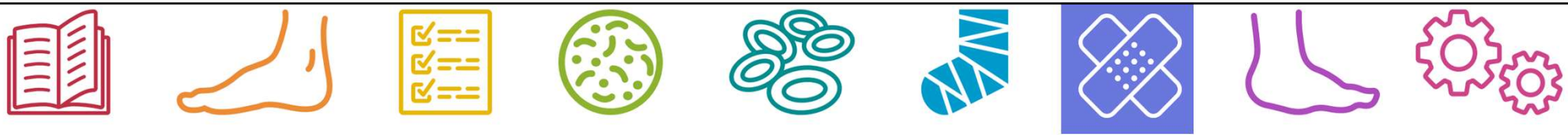
Key recommendations: new, different and positive

12. Consider the use of hyperbaric oxygen as an adjunct therapy in neuro-ischemic or ischemic diabetes-related foot ulcers where standard of care alone has failed and where resources already exist to support this intervention. (Conditional; Low)

13. Consider the use of topical oxygen as an adjunct therapy to standard care for wound healing in people with diabetes-related foot ulcers where standard of care alone has failed and resources exist to support this intervention. (Conditional; Low)

19. With the exception of the autologous leucocyte, platelet and fibrin patch we suggest not using autologous platelets therapy (including blood bank derived platelets) as an adjunct therapy to standard of care. (Conditional; Low)

20. Consider the use of autologous leucocyte, platelet and fibrin patch for diabetes-related foot ulcers as an adjunctive therapy to standard of care, where best standard of care alone has been ineffective, and where the resources and expertise exist for the regular venepuncture required. (Conditional; Moderate)



Key recommendations: new, different and positive

23. Consider the use of placental derived products as an adjunct therapy to standard care for wound healing in people with diabetes-related foot ulcers where standard of care alone has failed. (Conditional; Low)

28. Consider the use of Negative Pressure Wound Therapy as an adjunct therapy to standard of care for the healing of postsurgical diabetes-related foot wounds. (Conditional; Low).

28a. Do not use Negative Pressure Wound Therapy as an adjunct therapy to standard of care for the healing of non-surgically related diabetes foot ulcers (Strong; Low)