

Save Our Sole

Diabetic Foot & Ulcer Management

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Counties Manukau



Why Focus on the High-Risk Foot?

- Up to 1 in 3 people with diabetes will develop a foot ulcer
- Foot ulcers precede ~85% of diabetes-related L/L amputations
- 5y Mortality Rate – diabetes-related L/L amputation ~50-70%
- Diabetes is NZ's leading cause of kidney failure
- Dialysis patients face the highest risk of limb loss

References:
KDIGO CKD Guideline 2024
ADA Standards of Care 2025
IWGDF Prevention Guideline 2023





Neuropathy vs. Ischaemia

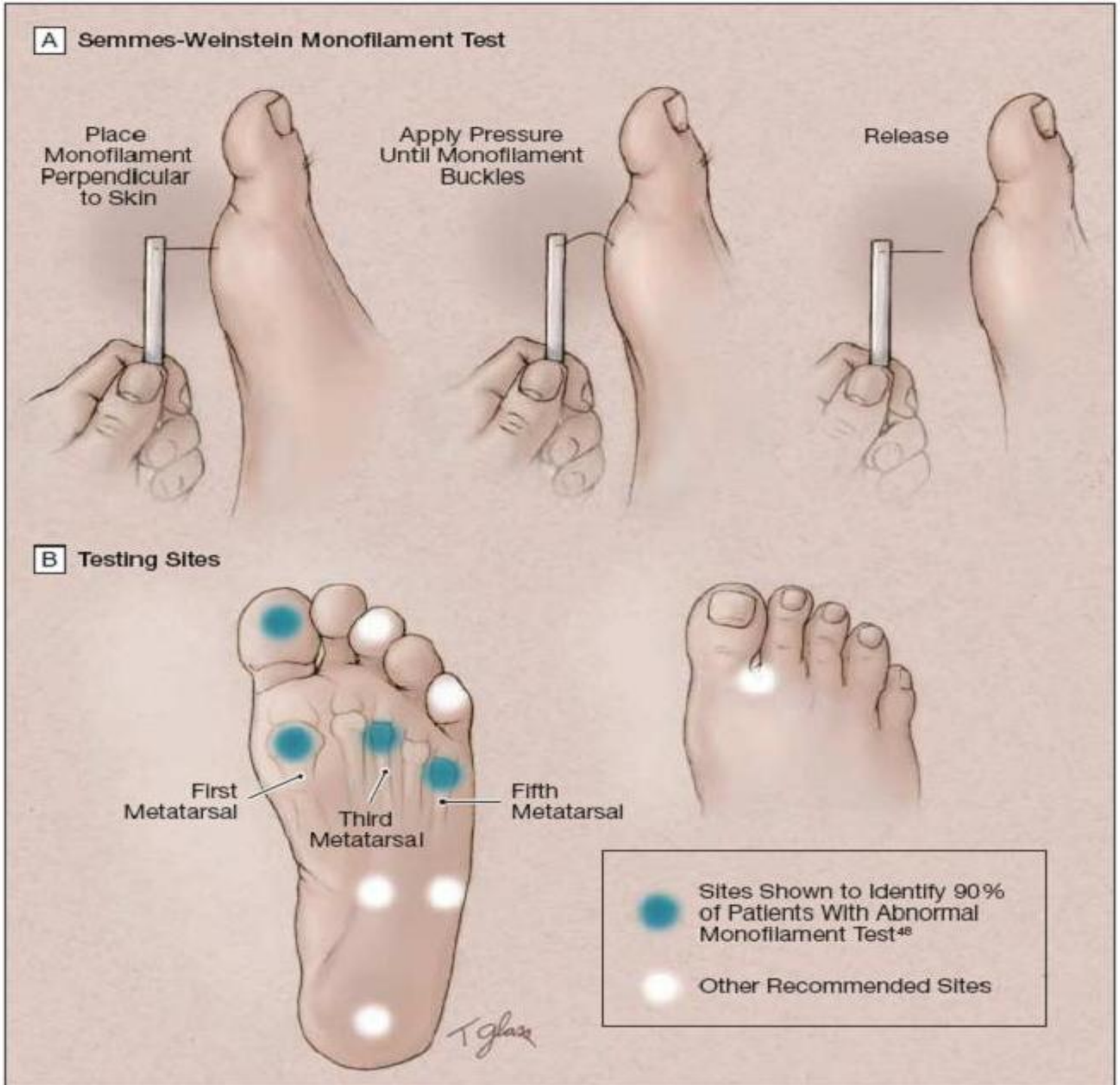
Types of Diabetic Foot

- Neuropathic foot = warm, dry, numb
- Ischaemic foot = cold, painful, poorly perfused
- Most diabetic patients present with mixed neuro-ischaemic disease
- Neuropathy + PAD + dialysis = the perfect storm



Neuropathy Assessment





Charcot Foot

- Common foot deformity related to neuropathic foot *i.e. Diabetes, Leprosy, CMT, injury etc…*
- unilaterally / bilaterally
- Acute stage presents as Red, Hot and Swollen foot
- Pain?



Charcot Foot

Charcot Arthropathy

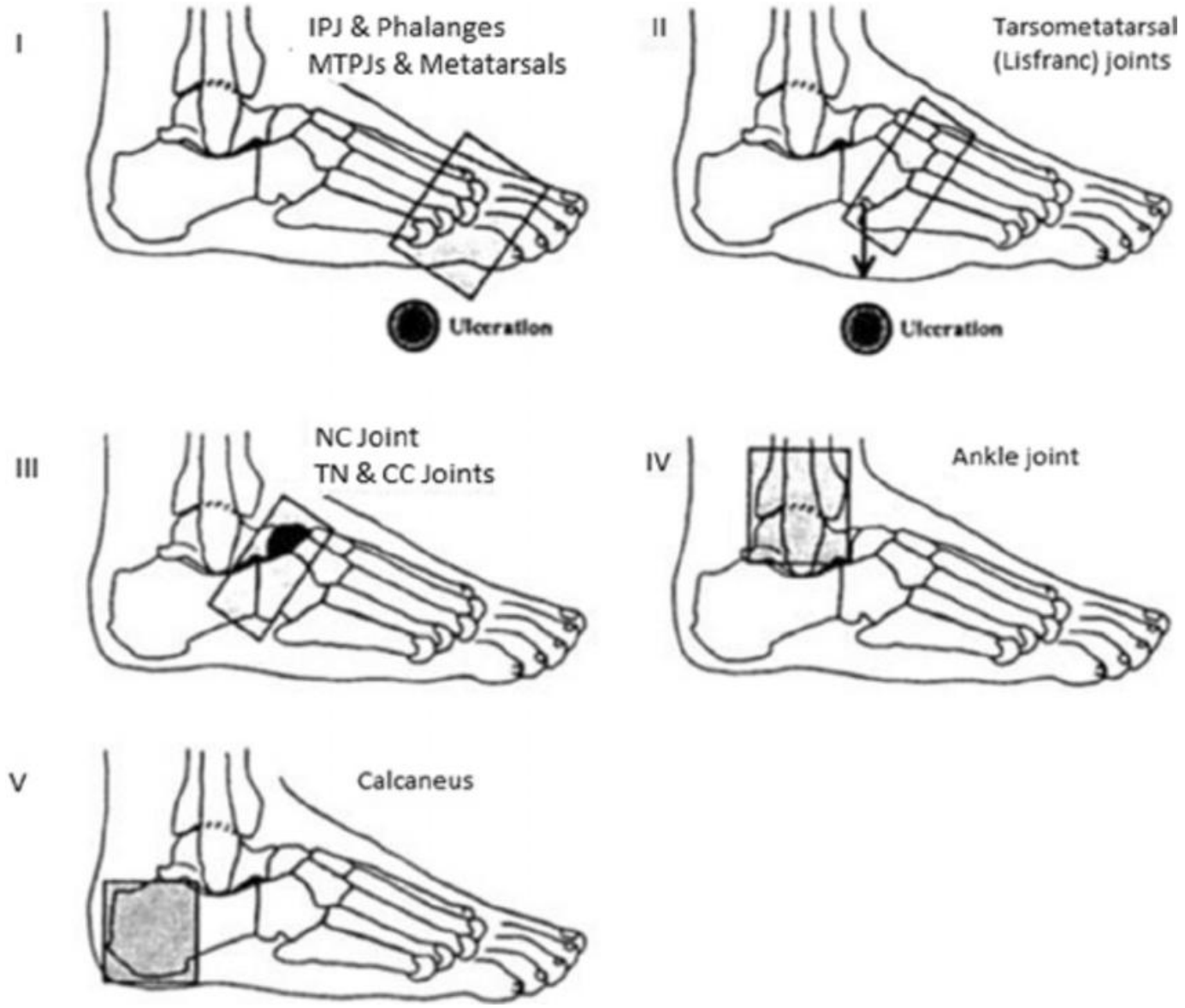
0. Early

1. Destructive

2. Coalescense

3. Consolidation

- Xray
- Offloading
- Orthopedic



Early Charcot – Stage 0

Infection?
Charcot?
Unsure?

Request Imaging




A


B

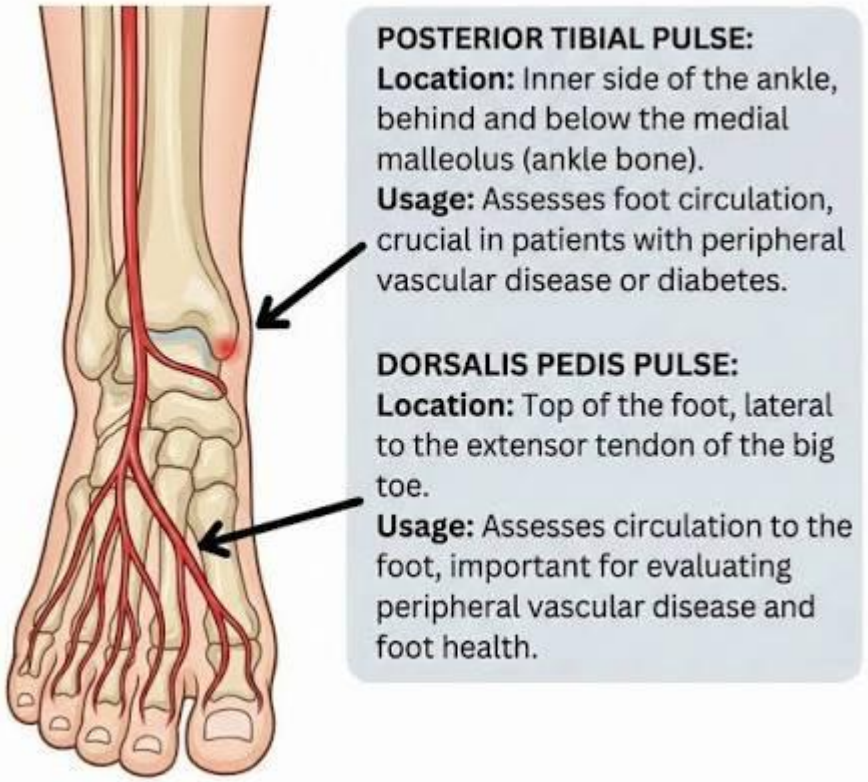

a


b

Vascular Assessment

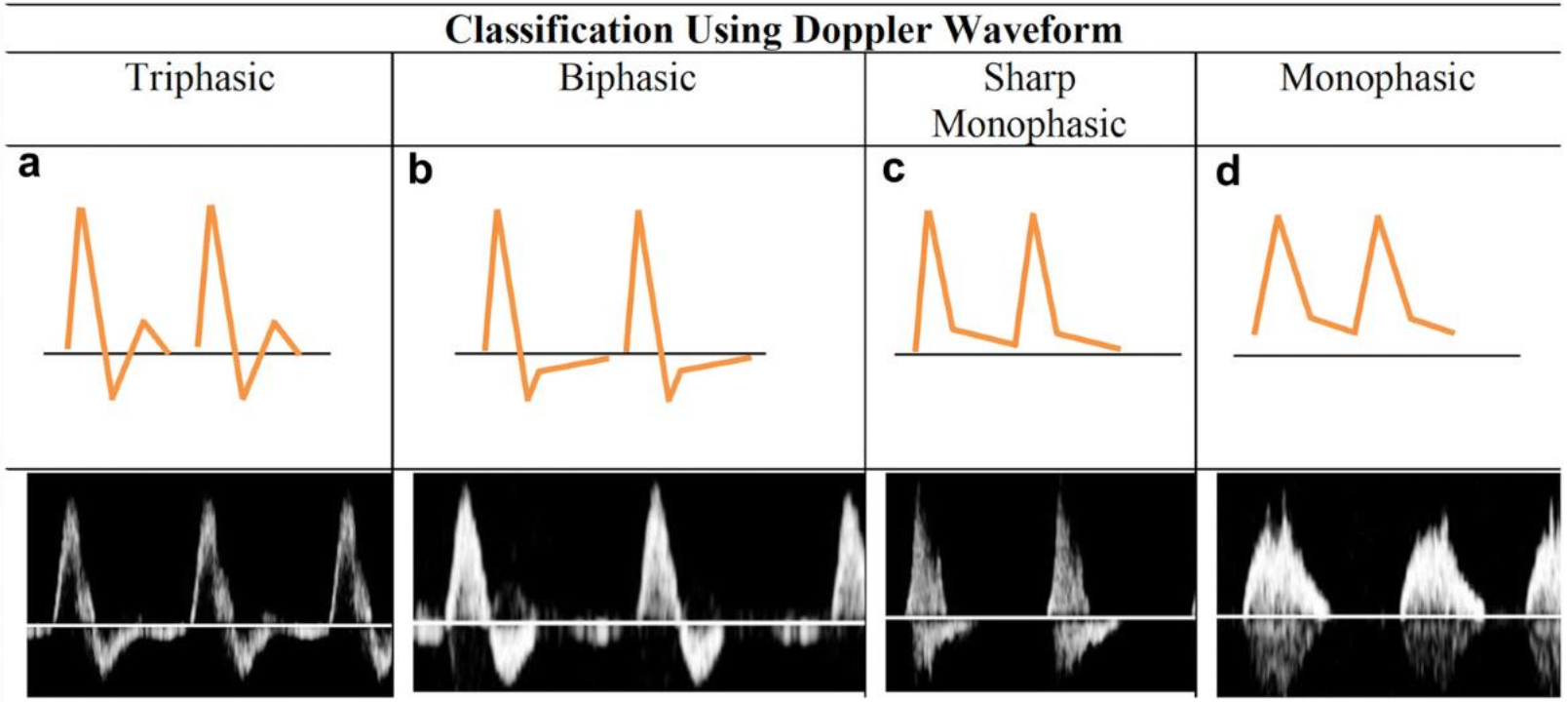
What Every Clinician Should Know





POSTERIOR TIBIAL PULSE:
Location: Inner side of the ankle, behind and below the medial malleolus (ankle bone).
Usage: Assesses foot circulation, crucial in patients with peripheral vascular disease or diabetes.

DORSALIS PEDIS PULSE:
Location: Top of the foot, lateral to the extensor tendon of the big toe.
Usage: Assesses circulation to the foot, important for evaluating peripheral vascular disease and foot health.

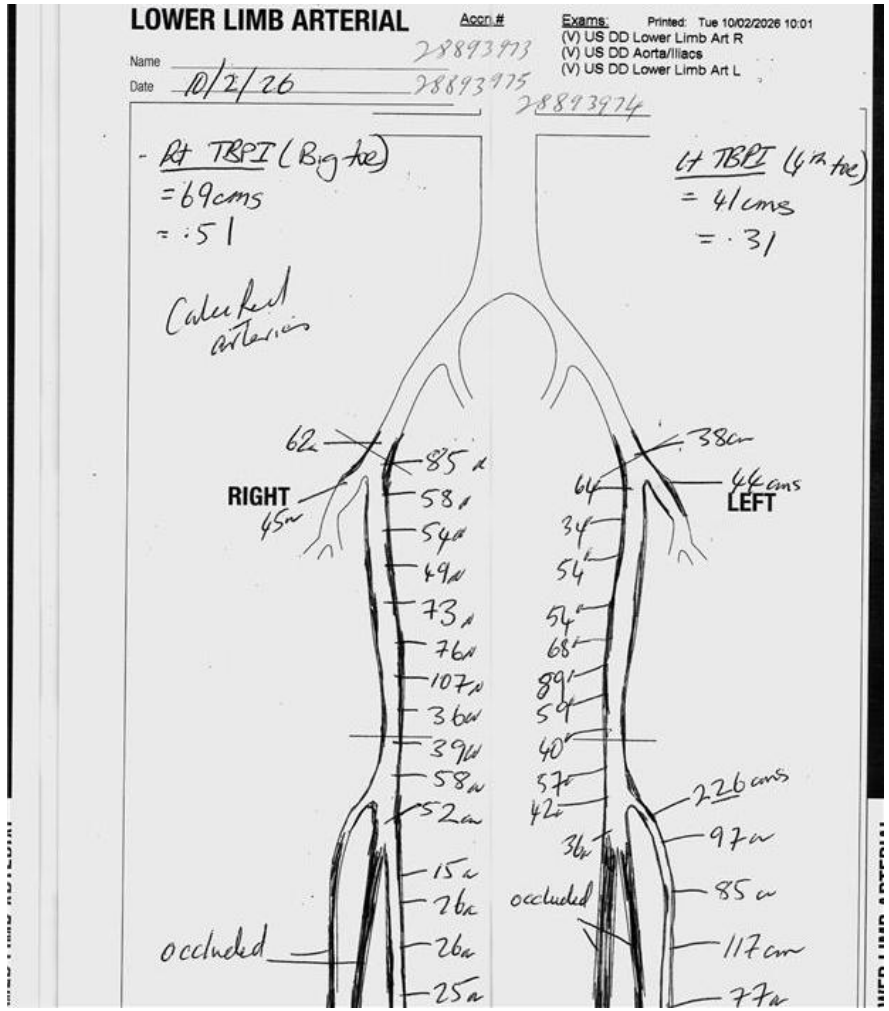


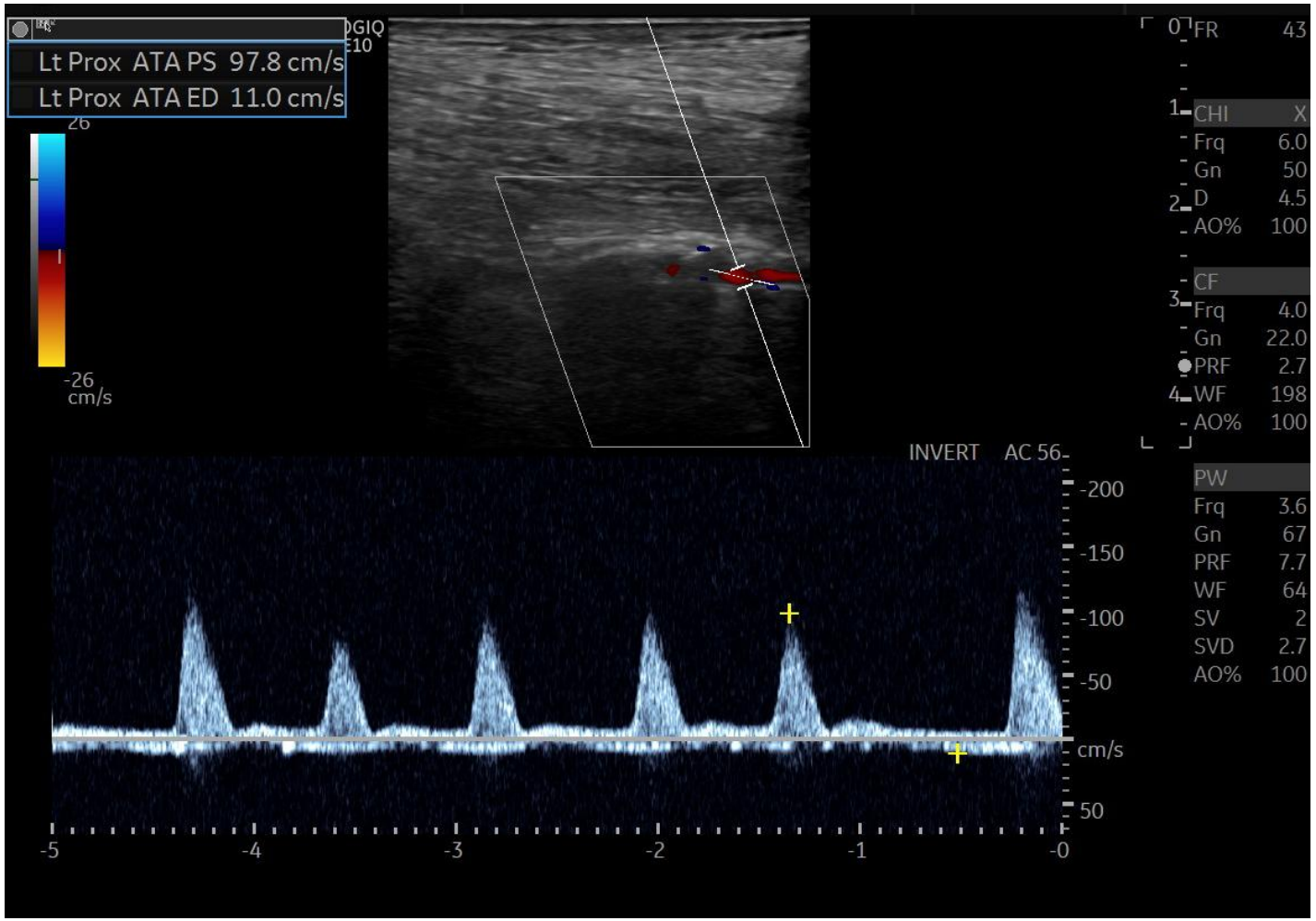
$$ABI = \frac{\text{Ankle Systolic Pressure}}{\text{Brachial Systolic Pressure}}$$

$$TBPI = \frac{\text{Toe Systolic Pressure}}{\text{Brachial Systolic Pressure}}$$

Resting ABPI	Severity of disease
>1.4	Calcification may be present
>1.0	Probably no arterial disease
0.81–1.00	No significant arterial disease, or mild/insignificant disease
0.5–0.80	Moderate disease
<0.5	Severe disease
<0.3	Critical ischemia

Treatment		
	Ischemia (a)	Severe isc. (b)
AP (mmHg)	< 100	< 50
ABI	–	< 0.4
TP (mmHg)	< 60	< 30


LOWER LIMB ARTERIAL
Accn #
Exams:
Printed: Tue 10/02/2026 10:01
(V) US DD Lower Limb Art R
(V) US DD Aorta/Iliacs
(V) US DD Lower Limb Art L
Name
Date 10/2/26
28893973
28893975
28893974
- Rt TBPI (Big toe)
=69cms
=.51
Lt TBPI (4th toe)
=41cms
=.31
Calcified arteries
RIGHT
LEFT
occluded
occluded


Lt Prox ATA PS 97.8 cm/s
Lt Prox ATA ED 11.0 cm/s
26
-26
cm/s
INVERT
AC 56
-200
-150
-100
-50
cm/s
50
-5
-4
-3
-2
-1
-0
FR 43
CHI X
Frq 6.0
Gn 50
D 4.5
AO% 100
CF
Frq 4.0
Gn 22.0
PRF 2.7
WF 198
AO% 100
PW
Frq 3.6
Gn 67
PRF 7.7
WF 64
SV 2
SVD 2.7
AO% 100

Necrosis

- Death of body tissue
- Usually due to lack of blood flow
- Can be cause by infection/injuries
- Often painful





VASCULAR ASSESSMENT PATHWAY FOR ACTIVE FOOT ULCER

1. ACTIVE FOOT ULCER



Any break in the skin below the ankle

2. PALPATE PEDAL PULSES



PULSES PRESENT & NORMAL
(easily palpable)

PULSES ABSENT / DIFFICULT TO ASSESS
(oedema, calcification, obesity)

3. DOPPLER ASSESSMENT



Handheld Doppler Assessment

BIPHASIC / TRIPHASIC WAVEFORM

MONOPHASIC / ABSENT SIGNAL

4. TOE PRESSURE ASSESSMENT



Measure Toe Pressure
(PREFERRED IN DIABETES)

(Use if Doppler biphasic/ triphasic OR if monophasic/ absent signal)

5. TOE PRESSURE RESULT

> 60 mmHg

ADEQUATE HEALING POTENTIAL

Continue Wound Care + Offloading + Review

30–60 mmHg

IMPAIRED HEALING POTENTIAL

Vascular Discussion Consider Duplex Ultrasound

< 30 mmHg

CRITICAL ISCHAEMIA UNTIL PROVEN OTHERWISE

URGENT VASCULAR REFERRAL Consider Imaging & Revascularisation

6. VASCULAR REFERRAL

Refer to Vascular Service for Assessment & Management

CONSIDER IMAGING

- Duplex Ultrasound
- CTA / MRA
- DSA (if indicated)

KEY POINTS

- People with diabetes: perform **toe pressure** assessment whenever possible.
- If ABI and toe pressure do not correlate, toe pressure guides the ischaemia grade.
- If arterial calcification makes ABI or toe pressure unreliable, use **$TcPO_2$, SPP or PVR** to document ischaemia.
- Ulcer + monophasic Doppler or rest pain = vascular referral.

ABBREVIATIONS

ABI = Ankle–Brachial Index
TBI = Toe–Brachial Index
$TcPO_2$ = Transcutaneous Oxygen Pressure
SPP = Skin Perfusion Pressure
PVR = Pulse Volume Recording

82-yo male with well-controlled diabetes
Referred for assessment of a **painful toe**, convinced he had a splinter

Clinical findings:

- Non-palpable pedal pulses
- Cold feet
- Painful toe
- claudication
- Increasing rest pain





Investigation Findings

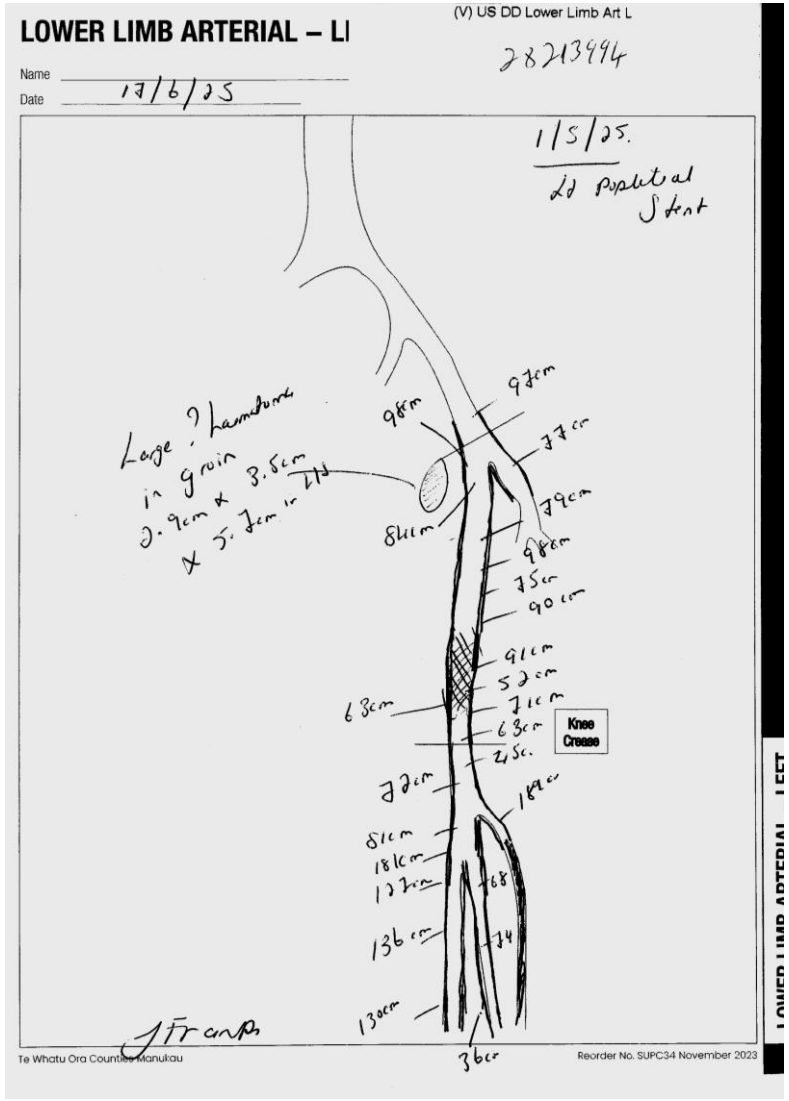
- Left popliteal artery **occlusion**
- **ABI: 0.15** (severe limb ischaemia)

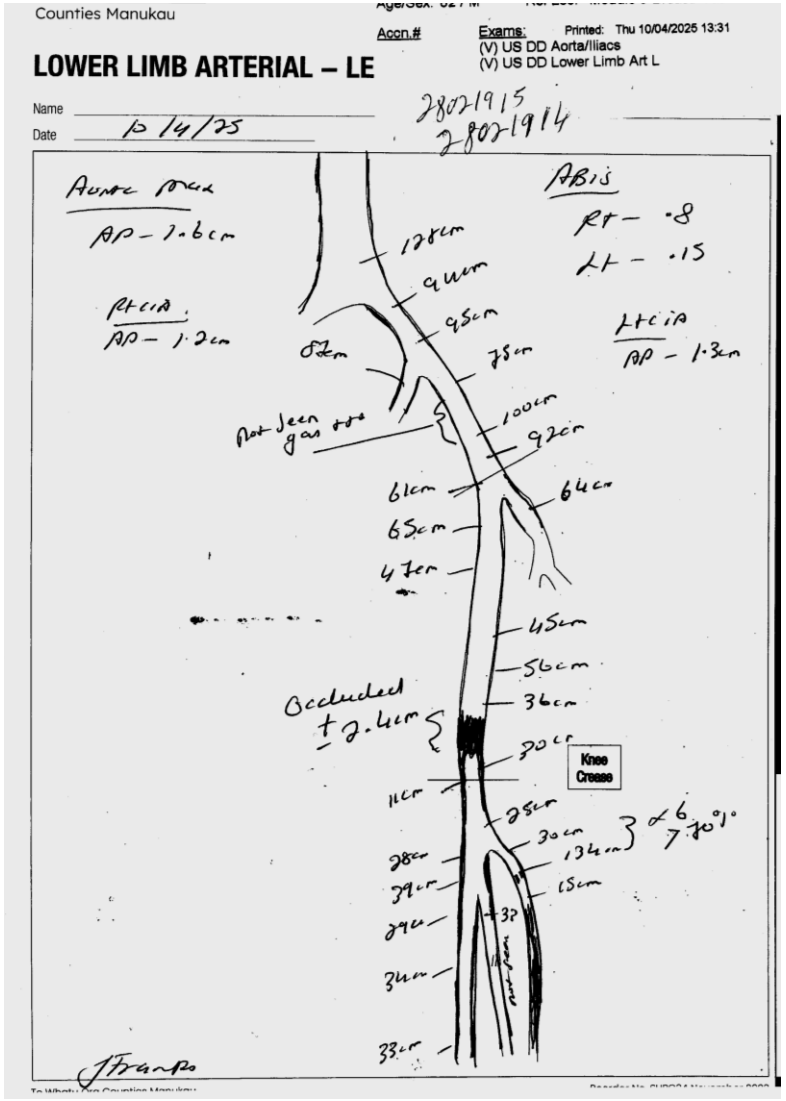
Vascular Intervention

- Open proximal superficial femoral artery (SFA) exposure
- Stenting of the left SFA and popliteal artery

Outcome

- Toe wound resolved within 1 week
- Rest pain significantly improved
- Foot warmth restored





Diabetic Foot Stratification

Category	Ulcer risk	Characteristics	Frequency*
0	Very low	No LOPS and No PAD	Once a year
1	Low	LOPS or PAD	Once every 6-12 months
2	Moderate	LOPS + PAD, *or* LOPS + foot deformity *or* PAD + foot deformity	Once every 3-6 months
3	High	LOPS or PAD, *and* one or more of the following: - history of a foot ulcer - a lower-extremity amputation (minor or major) - end-stage renal disease	Once every 1-3 months

* Screening frequency is based on expert opinion, since there is no published evidence to support these intervals.



Communicating Ulcer Characteristics

SINBAD

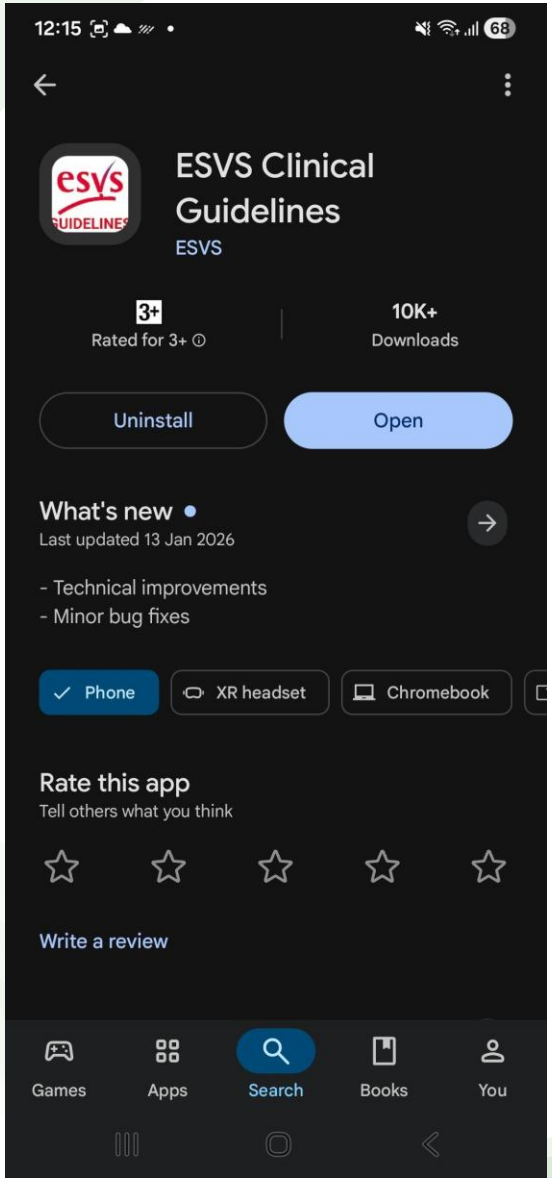
A Common Language for Diabetic Foot Ulcers

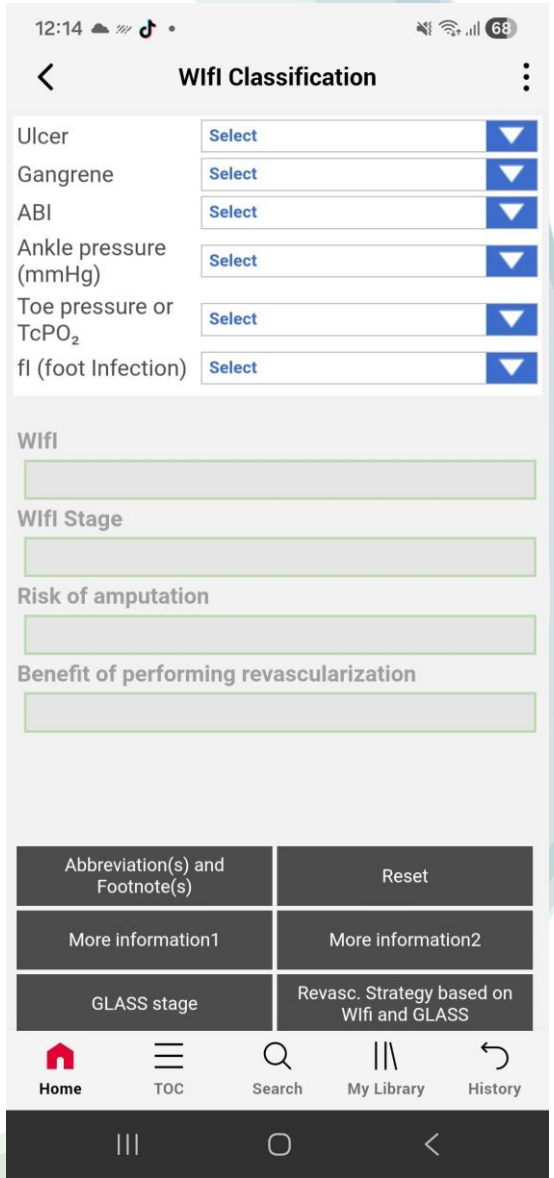
Category	Definition	SINBAD score
*S*ite	Forefoot	0
	Midfoot and hindfoot	1
*I*schemia	Pedal blood flow intact, one pulse palpable	0
	Clinical evidence reduced pedal blood flow	1
*N*europathy	Protective sensation intact	0
	Protective sensation lost	1
*B*acterial infection	None	0
	Present	1
*A*rea	Ulcer <1 cm^2	0
	Ulcer >1 cm^2	1
*D*epth	Ulcer confined to skin and subcutaneous tissue	0
	Ulcer reaching muscle, tendon, or deeper	1
Total possible score		0–6

Source: Adapted from Ince et al. (31).

WIfI

Will This Limb Heal?





The Wound, Ischemia, and Foot Infection (WIfI) classification system consists of 3 components graded separately from 0 (none) to 3 (severe).

One component may be dominant but the specific combination of scores is used to estimate the risk of limb amputation at 1 year and the need for or benefit of revascularization.[a]

Wound (W)

Grade	Ulcer	Gangrene
0	None	None
1	Small, shallow	None
2	Deep with exposed bone, joint, or tendon	Limited to digits
3	Extensive, deep, and involving forefoot and/or midfoot with or without calcaneal involvement	Extensive and involving forefoot and/or midfoot Full thickness heel necrosis with or without calcaneal involvement

Ischemia (I)

Grade	Ankle-brachial index Ankle systolic pressure	Toe pressure or transcutaneous oximetry
0	≥0.80 >100 mm Hg	≥60 mm Hg
1	0.60-0.79 70-100 mm Hg	40-59 mm Hg
2	0.40-0.59 50-69 mm Hg	30-39 mm Hg
3	≤0.39 <50 mm Hg	<30 mm Hg

Foot infection (fI)

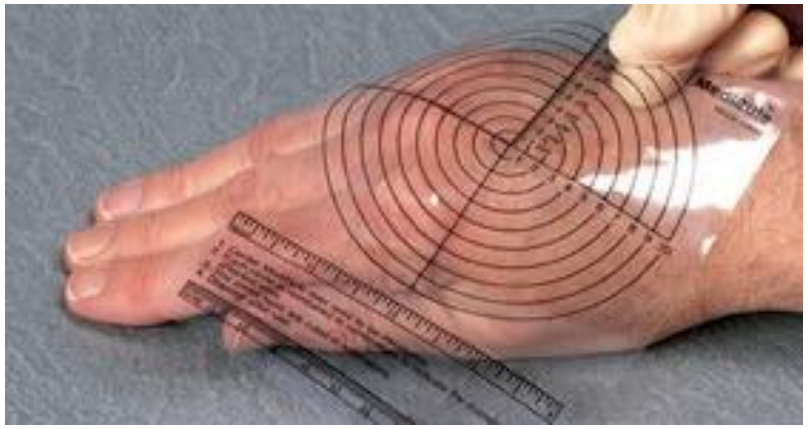
Grade	Clinical manifestation
0	No symptoms or signs of infection
1	Infection indicated by ≥2 of the following: • Local swelling or induration • Erythema 0.5-2.0 cm around ulcer • Local tenderness or pain • Local warmth • Purulent discharge (thick, opaque to white, or sanguineous)
2	Infection as described above with: • Erythema >2 cm around ulcer • Involving structures deeper than skin and subcutaneous tissues (eg, abscess, osteomyelitis, septic arthritis, fasciitis) • No signs of systemic inflammatory response (see below)
3	Infection as described above with ≥2 signs of systemic inflammatory response syndrome: • Temperature >38 °C or <36 °C • Heart rate >90/min • Respiratory rate >20/min or $PaCO_2$ <32 mm Hg • White blood cell count >12 000/μL or <4000/μL or 10% immature forms













Detailed Wound Assessment

63-year-old male with poorly controlled diabetes

- Historical HbA1c >100 mmol/mol
- Peripheral neuropathy present
- Initially presented with a **deep punch-out foot ulcer**

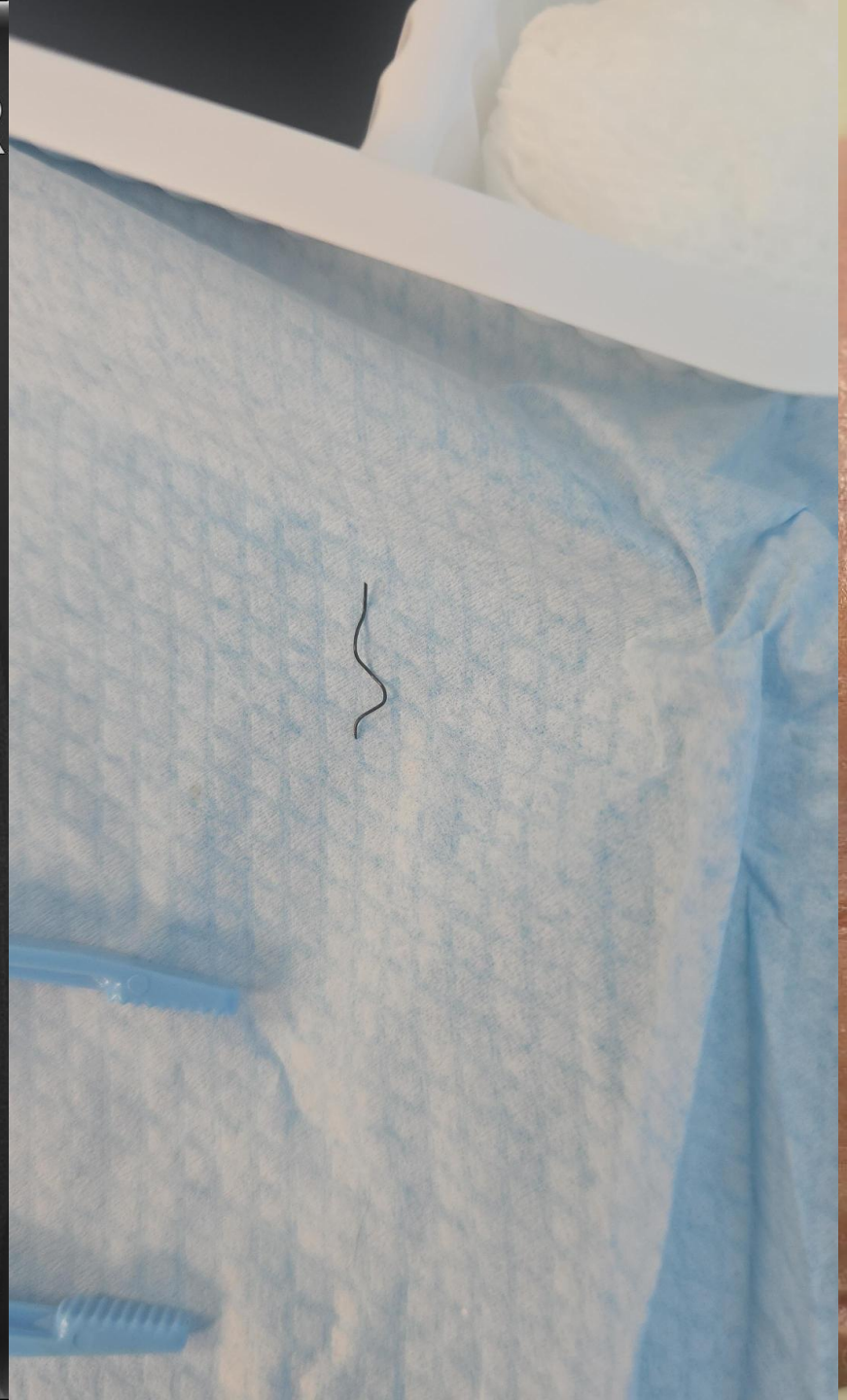
Recently discharged following:

- Sepsis
- Surgical washout
- Intravenous antibiotics
- Referred for a **second opinion** after wound deterioration despite:
- Acute diabetes management
- Ongoing wound care
- PAD assessment (subsequently ruled out)






R





Infection: Detection & Grading

Clinical Presentation	IDSA Infection Severity	Threatened Limb Class
Wound without inflammation or purulence	Uninfected	Not applicable
Presence of >2 manifestations of inflammation, cellulitis <2cm surrounding ulcer, no systemic symptoms of infection	Mild Infection	Non-limb threatening
Presence of infection with >2 cm of surrounding cellulitis; any infection with presence of gangrene, abscess, deep tissue involvement or gas in tissue; no systemic signs/ symptoms of infection	Moderate Infection	Limb threatening
Presence of infection as above with the presence of systemic signs or symptoms	Severe Infection	Life and limb threatening

Debridement

- Removal of non-viable tissue
- Removal of callus
- Removal of slough and debris
- Optimises wound healing environment









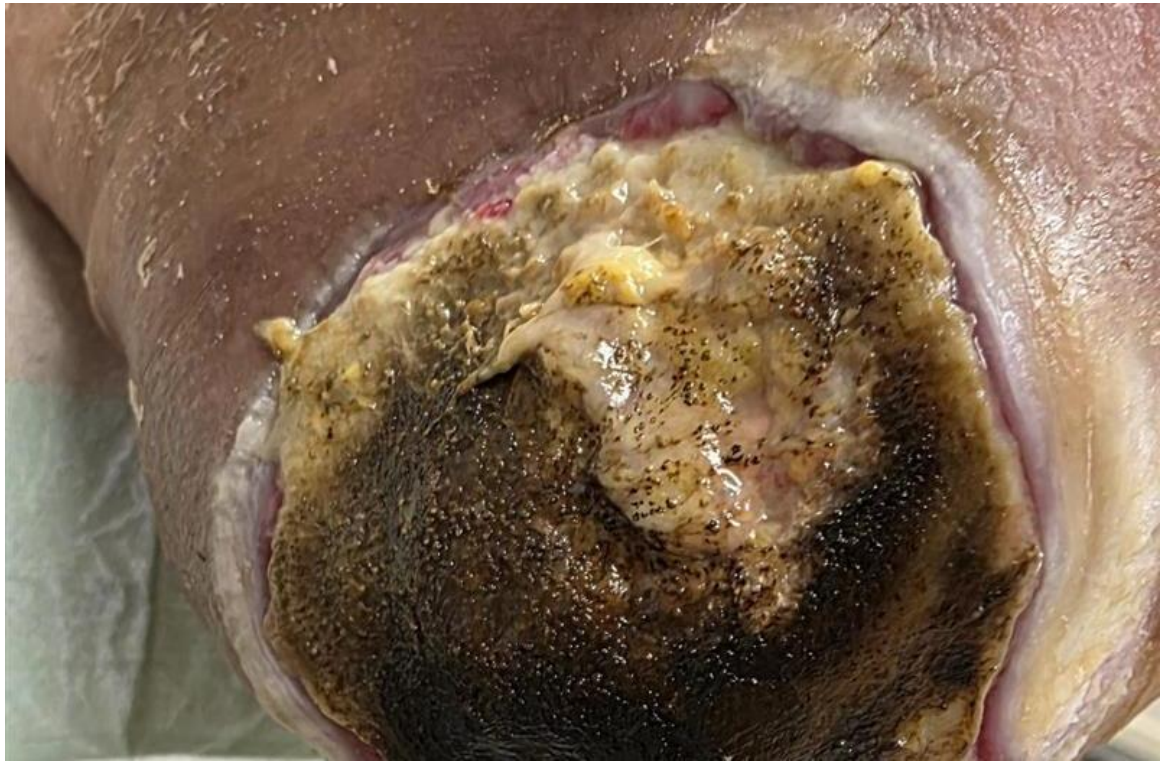


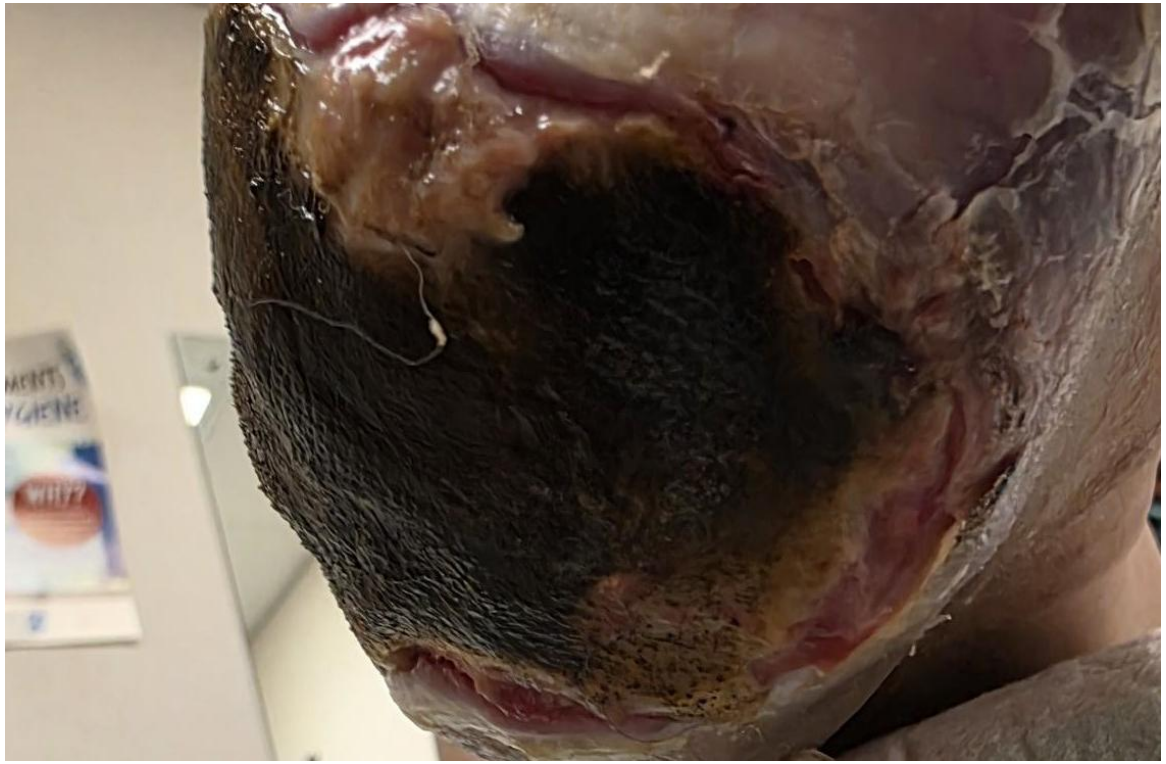


When & How Often?

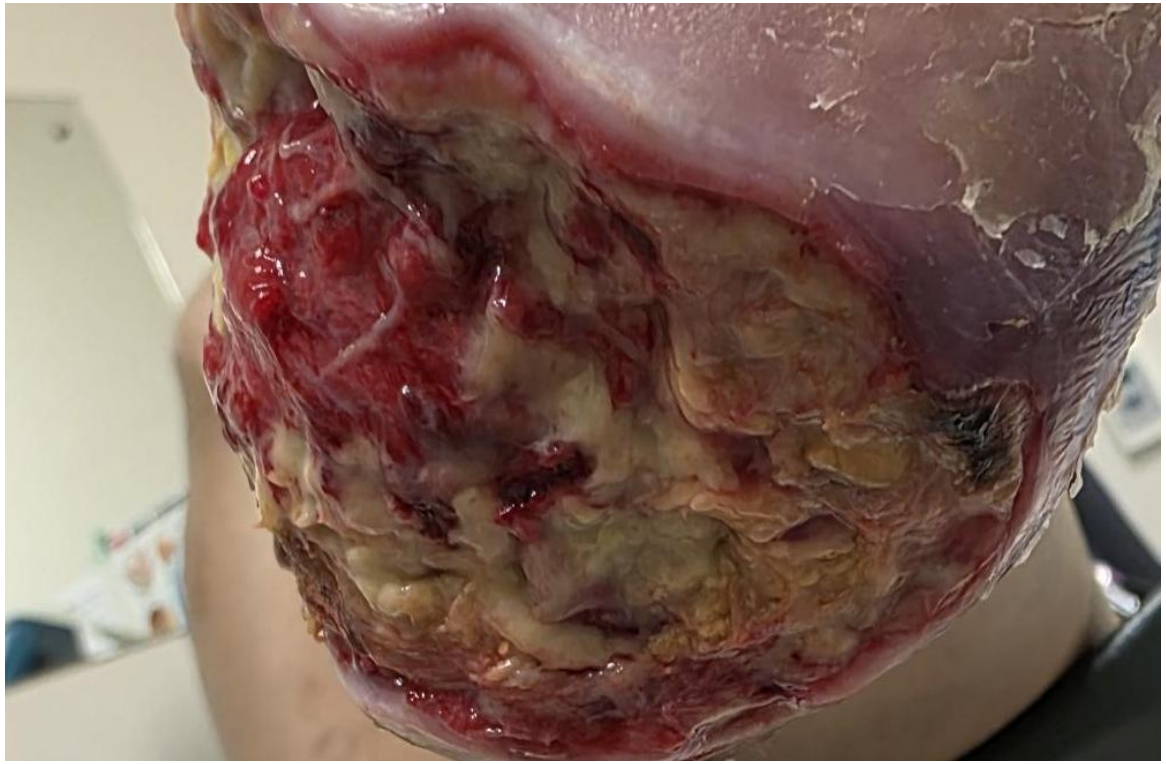
- Callus present
- Slough or devitalised tissue present
- Wound assessment obscured
- Pressure contributing to tissue breakdown

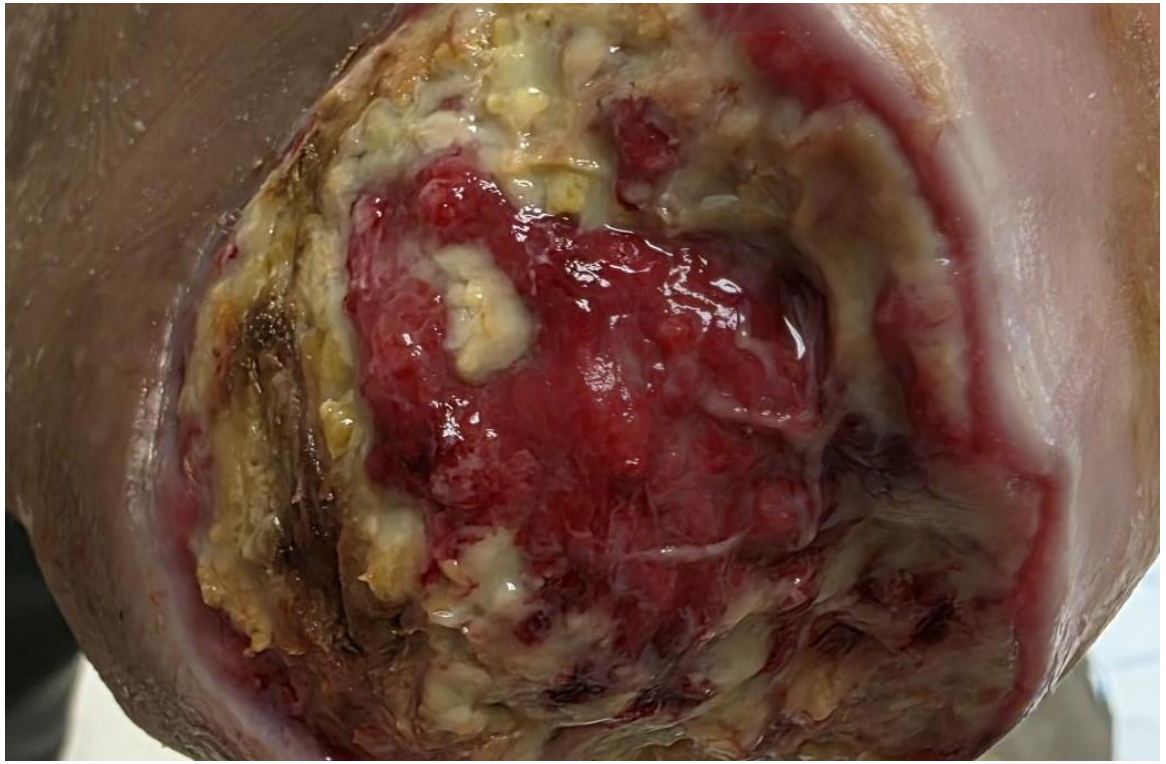
Case Example - 26 FEB 25



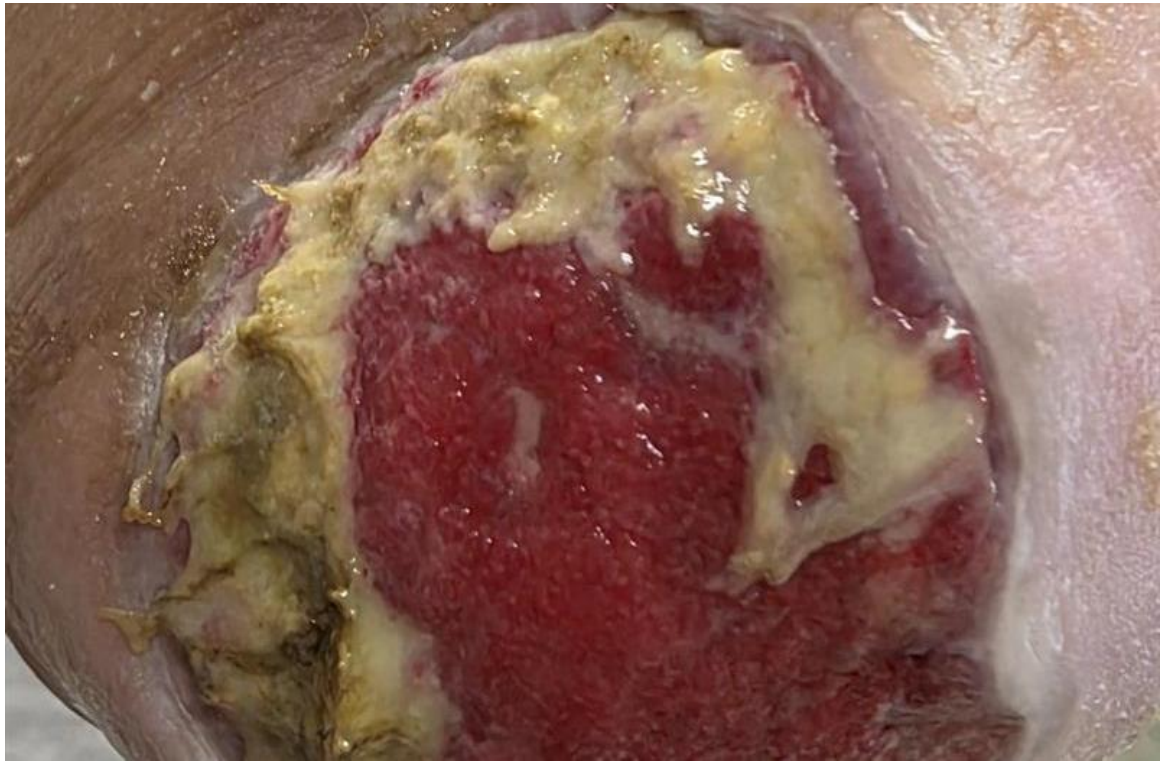


26 FEB 25 – Post Debridement



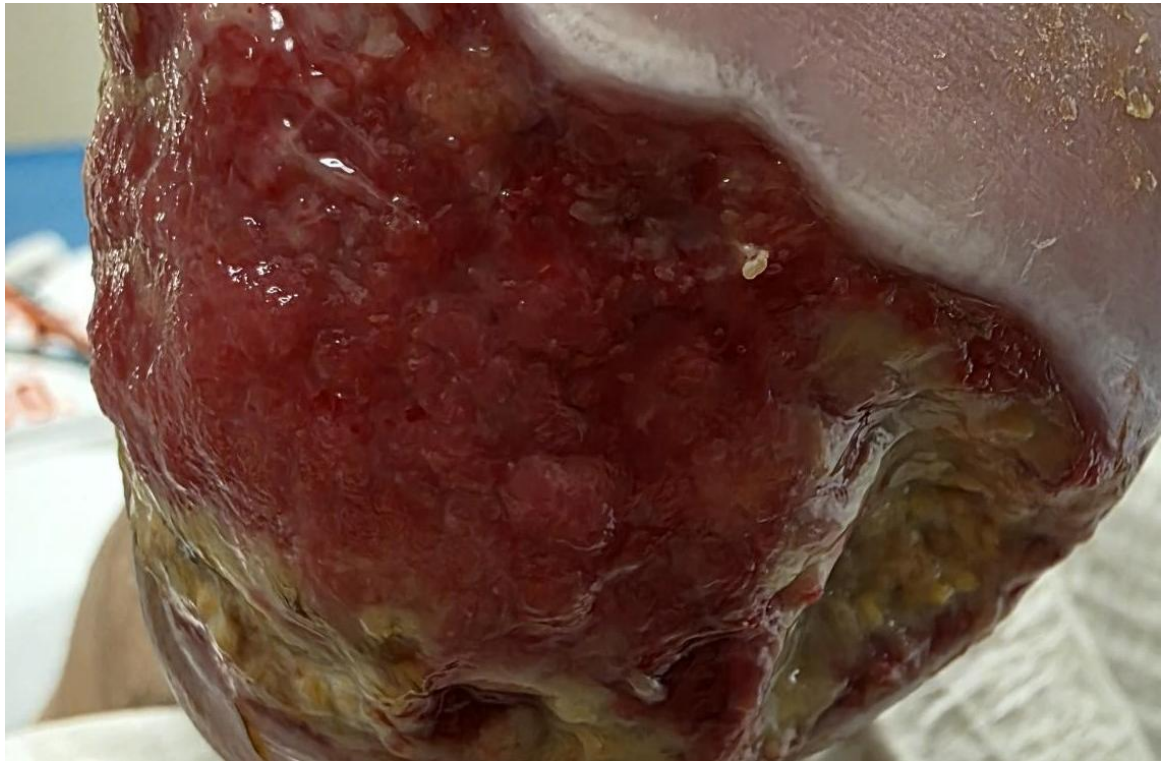


12 MAR 25





12 MAR 25 – Post Debridement



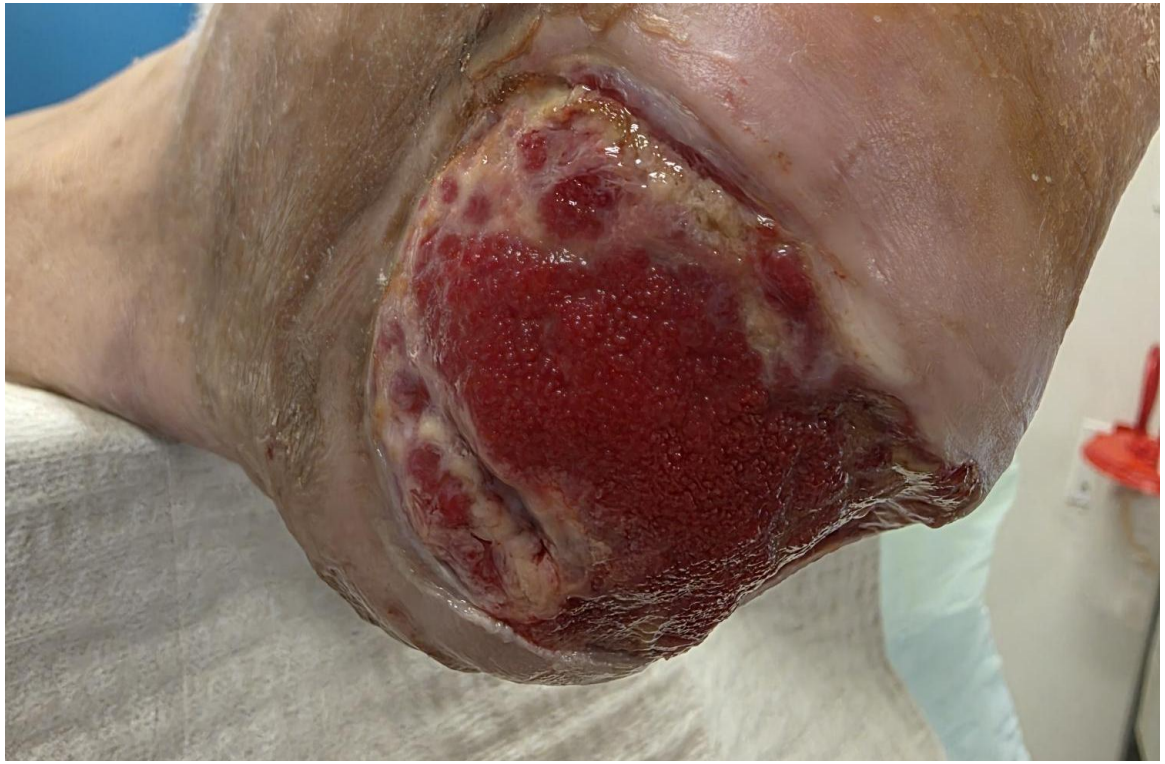


26 MAR 25





26 MAR 25 – Post Debridement





5 JUN 25





5 JUN 25 – Post Debridement





18 JUN 25





18 JUN 25 – Post Debridement





24 SEPT 25 - Total 7 months





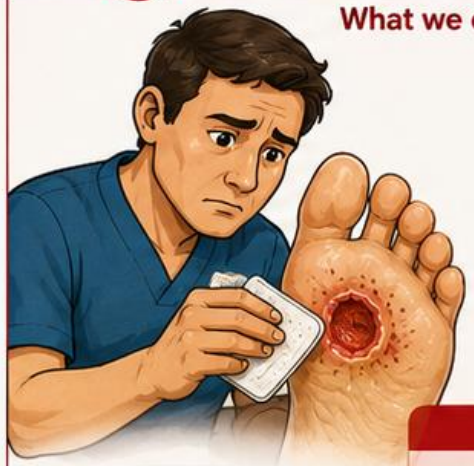
DIABETIC FOOT ULCER

TREAT THE CAUSE, NOT JUST THE SYMPTOMS

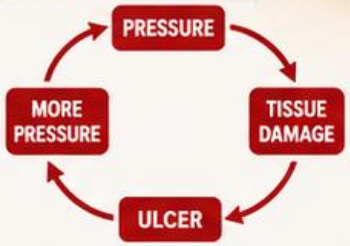
Wounds don't heal in a unhealthy foot. Address the cause. Create the conditions for healing.

✕ TREATING SYMPTOMS ONLY

What we often do...



- ✕ Just dress the wound
- ✕ Antibiotics alone
- ✕ Repeated dressing changes
- ✕ Focus on how the wound looks



THE PROBLEM

- The underlying cause remains
- Pressure continues
- Tissue damage continues
- Healing is slow or does not occur
- High risk of infection, recurrence and amputation



Same wound.
Different approach.
Different outcome.

✓ TREAT THE CAUSE

What leads to healing...



OFFLOAD PRESSURE
Remove pressure from the area using appropriate offloading (e.g., total contact cast, boot)



IMPROVE PERFUSION
Assess and optimise blood flow. Revascularise if needed.



MANAGE INFECTION
Identify and treat infection appropriately based on severity.



PREPARE THE WOUND BED
Debride non-viable tissue, manage exudate, and promote a healthy wound environment.



OPTIMISE SYSTEMIC FACTORS
Glycaemic control, nutrition, stop smoking, and manage comorbidities.



THE RESULT

- ✓ Pressure removed
- ✓ Wound environment improves
- ✓ Tissue can heal
- ✓ Lower risk of recurrence and amputation

A dressing is important, but it cannot heal what pressure is destroying.

THE KEY PILLARS OF DIABETIC FOOT ULCER HEALING





DON'T JUST TREAT THE WOUND.
TREAT THE PATIENT.
TREAT THE CAUSE.
THAT'S HOW WE CHANGE OUTCOMES.

ASSESS THOROUGHLY • ADDRESS THE CAUSE • WORK AS A TEAM • EMPOWER THE PATIENT • PREVENT RECURRENCE

OFFLOADING: THE CORNERSTONE OF NEUROPATHIC ULCER HEALING

Remove the pressure. Enable the healing.



- Pressure causes tissue breakdown.
- Pressure must be reduced for healing.

GOLD STANDARD

Most effective for plantar neuropathic ulcers

TOTAL CONTACT CAST (TCC)



Evenly redistributes pressure across the entire foot

NON-REMOVABLE KNEE-HIGH WALKER



Almost as effective as TCC with fewer resources

Both TCCs and non-removable walkers significantly improve healing vs. simple shoes.

ALTERNATIVES

REMOVABLE WALKER



Use if TCC not possible. Consider strapping if adherence is an issue.

OFFLOADING FOOTWEAR



Special off-loading shoes reduce pressure on ulcer area.

FELT PADDING



Offloads pressure by redistributing weight away from ulcer.

CUSTOM ORTHOSES



Custom insoles help redistribute plantar pressure more evenly.

FOOTWEAR MODIFICATIONS



Rocker sole, accommodative footwear, extra depth shoes and more.

Goal: No pressure on the ulcer area. Protect the wound with every step.

PRACTICAL CONSIDERATIONS

Dialysis patients often have oedema
Consider swelling changes and device fit.

Consider balance and falls risk
Choose the safest device for the individual.

Maintain safe mobility where possible
Promote independence and quality of life.

Multidisciplinary approach improves outcomes
Involve podiatry, nursing, physiotherapy, OT, orthotics, and medical teams.

THE IMPACT OF OFFLOADING

WITHOUT OFFLOADING



- ✕ High pressure on ulcer
- ✕ Ongoing tissue damage
- ✕ Delayed healing
- ✕ Higher risk of infection and amputation

VS.

WITH OFFLOADING



- ✓ Pressure redistributed
- ✓ Protected wound
- ✓ Faster healing
- ✓ Lower risk of complications
- ✓ Better outcomes

KEY MESSAGE

"Offloading doesn't stop patients moving. It allows them to move more safely while protecting the wound."



REMEMBER

- Assess the patient
- Choose the right device
- Educate and involve the patient
- Review regularly
- Adjust as needed

TREAT THE CAUSE. REMOVE THE PRESSURE. ENABLE HEALING. | OFFLOADING IS THE FOUNDATION OF DIABETIC FOOT ULCER HEALING.

OFFLOADING MUST BE SAFE

Balance pressure relief with safe mobility and independence

The best offloading plan is one that reduces pressure and the patient can safely use.

OFFLOADING MUST BE SAFE

- Reduce pressure while maintaining mobility
- Consider balance and falls risk
- Dialysis patients often have frailty and sarcopenia
- Assess home environment
- Use walking aids when required
- Involve physiotherapy and occupational therapy

Safety first. Healing follows.

PRACTICAL CONSIDERATIONS

- Uneven surfaces



- Stairs



- Transport to dialysis



- Device adherence



- Home safety modifications



Small changes at home can prevent falls and support healing.

ENCOURAGE

- Reduced unnecessary walking



- Seated exercise



- Physiotherapy-guided activity



- Maintaining independence where possible



Stay active in safe ways to protect your health and independence.



KEY MESSAGE

"The goal is not to stop patients moving. The goal is to help them move safely while protecting the foot."

Protect the foot.
Prevent falls.
Promote healing.
Preserve independence.

REDUCE PRESSURE + MAINTAIN MOBILITY + IMPROVE SAFETY + BETTER OUTCOMES = WITH CONFIDENCE

TEAMWORK MAKES THE DIFFERENCE

Podiatry • Nursing • Physiotherapy
OT • Dietetics • Nephrology • Social Work

Oedema Matters in Renal Patients

Swelling changes everything – assess, manage, and re-assess.

WHY OEDEMA MATTERS

Alters tissue mechanics
Increases tissue tension and skin stress

Increases shear forces
Higher risk of breakdown during walking

Impairs microcirculation
Reduces oxygen and nutrient delivery to tissues

Challenges offloading
Affects cast/boot fit, wound assessment and footwear

Must be assessed
Document oedema at every wound review

OEDEMA CHANGES TISSUE MECHANICS

SWOLLEN LEG

Poor fit, higher pressure, more risk to skin



Increased pressure = Increased risk

DECONGESTED LEG

Better fit, lower pressure, better outcomes



- Improved contours
- Lower shear forces
- Better perfusion
- Supports healing

Reduced pressure = Better healing

MANAGEMENT STRATEGIES

Optimise fluid balance
Work with renal team to achieve dry weight

Time it right
Assess and adjust offloading post-dialysis when legs are drier

Elevate limbs
Raise legs between dialysis sessions when possible

Consider compression (if safe)
Only if arterial supply is adequate – check vascular status first

Choose adjustable footwear & devices
Accommodate daily changes in limb volume

Review regularly
Reassess fit and pressure each visit

TAKE ADVANTAGE OF DIALYSIS TIMING

PRE DIALYSIS
More fluid
More swelling
Poorer fit



POST DIALYSIS
Less fluid
Less swelling
Better fit

Ideal time for wound review, dressing changes, offloading adjustments, footwear and orthotic review.

COMPRESSION – USE WITH CAUTION

- ✓ Use only if arterial inflow is adequate
- ✓ Monitor skin integrity
- ✗ Avoid if arterial disease is significant
- ✗ Never apply too tight

PRACTICAL EXAMPLES – FIT WILL CHANGE!



DON'T FORGET

- Edema changes daily
- Tissue mechanics change
- Pressure distribution changes
- Offloading may be less effective
- Reassess fit and strategy at every visit



KEY MESSAGE

If oedema changes, tissue mechanics change.

If tissue mechanics change, pressure and healing change.

Never assume yesterday's plan is right today.



Multidisciplinary care improves outcomes

Optimise dialysis and nutrition

Protect the skin
Manage the oedema

Right fit today for better healing tomorrow

"Every swollen leg is different. Every day is different. So are our plans."

Funded Referral – Peke Waihanga

Contact Us

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SAVE OUR SOLE

WHEN TO ESCALATE

Act Early. Involve the Right People. Save the Limb.

Timely escalation prevents amputation and preserves independence.

ESCALATE URGENTLY IF:

- Suspected critical limb-threatening ischaemia (ABI < 0.5 or toe pressure < 30 mmHg)
- Uncontrolled infection
- Deep tissue involvement / abscess
- Rapidly deteriorating tissue or necrosis

The longer we wait, the fewer options remain to save the limb.

REASSESS IF HEALING STALLS

IWGDF recommends reassessment if a diabetic foot ulcer is not healing after **4–6 weeks** of appropriate care.



Expect ~50% reduction in ulcer area by 4 weeks.

If not, re-evaluate and escalate.

DIABETIC FOOT CARE PATHWAY

IDENTIFY – Early detection of risk and new lesions

ASSESS – Clinical exam, vascular status, neuropathy, infection

OFFLOAD – Remove pressure and optimise mobility

TREAT INFECTION – Prompt antibiotics and source control

RESTORE PERFUSION – Assess and revascularise where indicated

MDT REVIEW – Escalate early involve the right team

HEAL LIMB – Promote healing, prevent recurrence

DOCUMENT CLEARLY

- Record all findings
- Record concerns
- Record escalation plan
- Document referrals and discussions

The next clinician should know what you found, what you are worried about, and what action has been taken.

KEY QUESTIONS TO ASK

- Has the pressure truly been removed?
- Is there an unrecognised infection?
- Is there underlying osteomyelitis?
- Is there an unrecognised vascular problem limiting healing?

If uncertain, investigate further and seek specialist review.

MULTIDISCIPLINARY DIABETIC FOOT SERVICE

Working together for the best outcomes



VASCULAR SURGERY – Revascularisation and advanced interventions

INFECTIOUS DISEASES – Antibiotic management and infection advice

DIABETES MEDICINE – Glycaemic control and medical optimisation

RADIOLOGY – Imaging for diagnosis and intervention

PODIATRY – Offloading, footwear, wound care expertise

ORTHOTICS – Custom devices and pressure offloading

NURSING & COMMUNITY – Ongoing care, education, and follow-up

Involve the right people early – don't wait until options are limited.

THE ROLE OF DIALYSIS SERVICES

- Foot inspection at every dialysis visit
- Early identification of new lesions
- Patient education and self-care support
- Prompt referral for any concerns



Early detection in dialysis units saves limbs.

SUSPECTED OR CONFIRMED OSTEOMYELITIS



- Multidisciplinary discussion essential
- Imaging (X-ray, MRI)
- Microbiology (bone biopsy)
- Infectious diseases input
- Surgical assessment
- Consider antibiotics, resection or other interventions

Coordinated care improves outcomes.

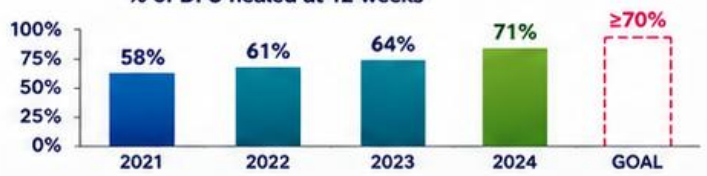
OUR GOAL: PRESERVE MOBILITY. MAINTAIN INDEPENDENCE. PREVENT HOSPITALISATION. AVOID AMPUTATION. → **IMPROVE QUALITY OF LIFE.**

SAVE OUR SOLE

Key Take Home Messages

1. Look at the feet regularly
2. Perform a neurovascular assessment
3. Document ulcers clearly (SINBAD, IDSA, WIfI where appropriate)
4. Identify infection early
5. Optimise the wound bed
6. Offload effectively
7. Reassess wounds that are not progressing
8. Escalate concerns early
9. Utilise the multidisciplinary team

LOCAL AUDIT – DFU HEALING AT 12 WEEKS



Aim: ≥70% healing at 12 weeks

Our Pathway to Better Outcomes

1. **SCREEN** – Screen at every visit and annually
2. **ASSESS** – Neurovascular assessment
3. **CLASSIFY** – Document ulcers clearly (SINBAD, IDSA, WIfI where appropriate)
4. **DEBRIDE** – Debride regularly to optimise the wound bed
5. **DRESS** – Use appropriate moist dressings
6. **OFFLOAD** – Offload pressure effectively
7. **ESCALATE** – Escalate early if healing stalls or concerns arise
8. **HEAL** – Heal the ulcer, prevent recurrence and protect mobility

Prevention today. Mobility tomorrow.

> **"The best Foot Ulcer management is the one that *never happened***

Early recognition.
Early intervention.
Better outcomes.

Counties Manukau Health | Te Whatu Ora Health New Zealand

USEFUL NZ FOOT CARE RESOURCES

- Health New Zealand – Diabetic Foot Care healthify.nz/diabetes-foot-care
- NZ Society of Podiatrists – Foot Health podiatry.org.nz
- NZSSD – Clinical Guidelines nzssd.org.nz

KEY REFERENCES

- IWGDF Guidelines on the prevention and management of diabetic foot disease (2023)
- IWGDF Guidelines on the diagnosis and treatment of diabetes-related foot infections (2023)
- IWGDF Guidelines on diagnosis, prognosis and management of PAD in patients with a foot ulcer and diabetes (2023)
- NZSSD Diabetic Foot Complications Best Practice Guideline (2022)
- Health New Zealand – Diabetic Foot Care Pathway (2024)

Questions & Discussion

Guideline Reference

- International Working Group on the Diabetic Foot (IWGDF). Guidelines on the Prevention and Management of Diabetes-related Foot Disease. 2023.
- American Diabetes Association. Standards of Care in Diabetes 2025.
- Kidney Disease: Improving Global Outcomes (KDIGO). CKD Guideline 2024.
- New Zealand Society for the Study of Diabetes (NZSSD). Diabetic Foot Special Interest Group Resources. 2024.
- New Zealand Wound Care Society (NZWCS). Best Practice Guideline. 2024.
- Australian & New Zealand Society for Vascular Surgery. Chronic Limb Threatening Ischaemia Guideline. 2024.
- ANZDATA Registry Annual Report. 2024.
- Te Whatu Ora Health New Zealand. Diabetes and Equity Reports. 2024.

COUNTIES MANUKAU HEALTH

Save Our Sole

OFFLOADING WORKSHOP

Effective Pressure Relief. Better Healing. Stronger Outcomes.

- ASSESS RISK
- REDUCE PRESSURE
- USE EFFECTIVE OFFLOADING
- WORK TOGETHER
- PREVENT AMPUTATION



Every step we take can save a limb.

Practical knowledge.
Real impact.





FPIM
S/M/L/XL

OSSUR SHOE DH OFFLOAD

Easily Customised Cost Effective

Temporary device



Moonboot/Removable Cast Walker

- FPIM
  SIZE: S/M/L/XL





Diabetic Footwear/Orthotics and Offloading Device (Funded Pathway)

Peke Waihanga
Artificial Limb Service

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OTOFORM

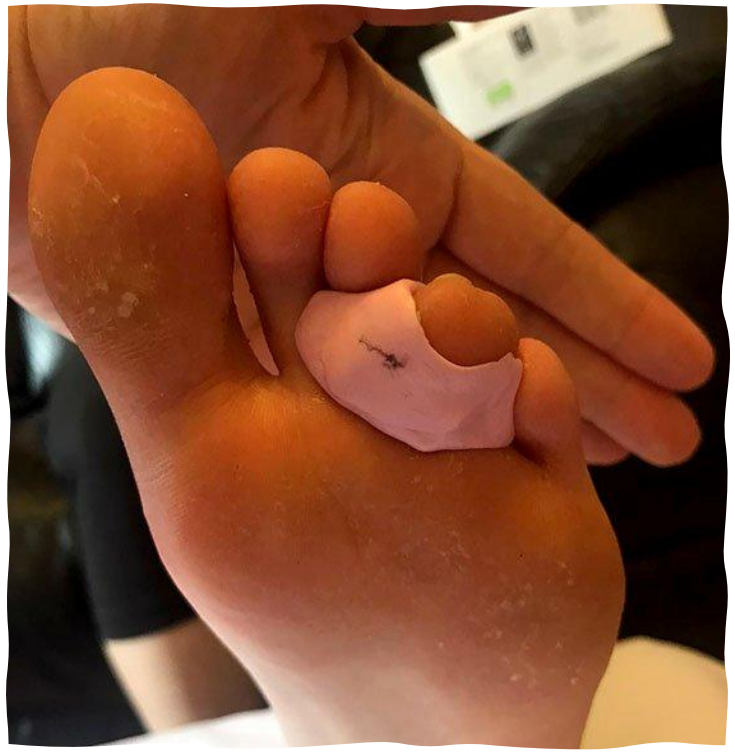
Non-Catelogue Order – Whiteley Allcare NZ

https://allcare.co.nz/products/otoform-silicone

Playdough for ADULTS

Tutorial: https://youtu.be/lL4_E_DlCgc?si=NGW0LWVNjVwUo6qx











Hapla Mixture Felt

Non-Catelogue Order – Whiteley Allcare NZ

22.5cm x 45cm per sheet

https://allcare.co.nz/products/hapla-semi-compressed-felt



Thickness

- 5mm vs 10mm
- Compressable





Compared to Padded Dressing





Crafting for Adults



Mark > Cut > Stick

- 3-5mm diameter around ulcer







Always apply felt over Dressings

Goal to migrate pressure away from the ulcer

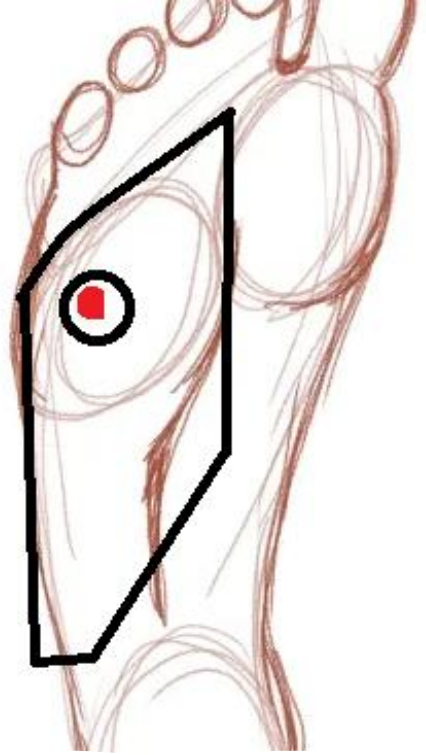


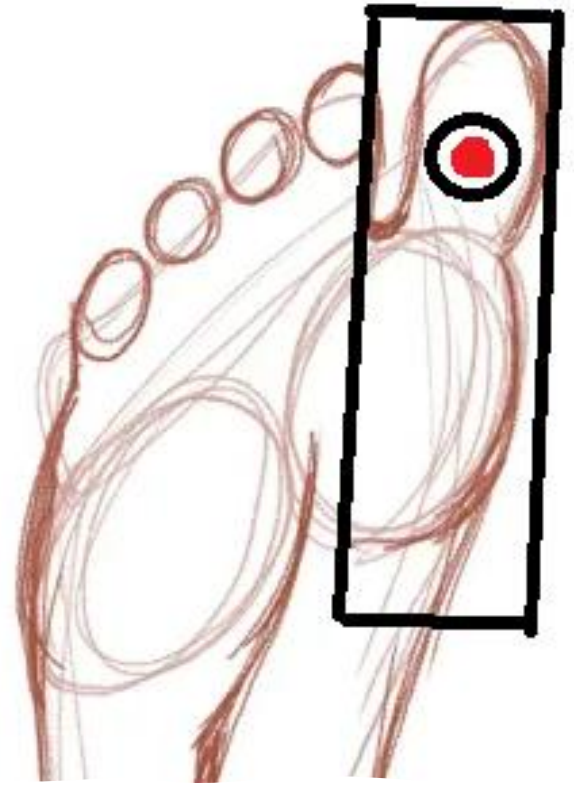
NEVER Make them too small

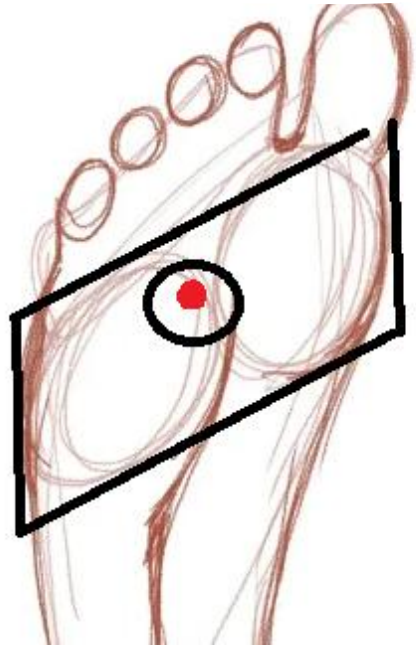
Consider Felt Surface Area to migrate/redistribute Pressure

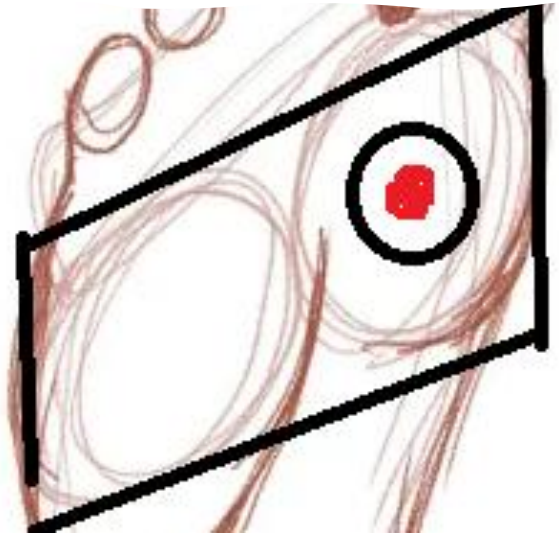
Forefoot Technique

- Be creative









Rearfoot Technique

Use 1cm thickness for best results







Thank you

By Elson Ng

Professional & Clinical Lead - Podiatry Service

Division of Diabetes, Rheumatology, Renal,
Community Health Counties Manukau Health

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