

CASE REPORT: CASE OF DIABETIC FOOT ULCER ASSOCIATED WITH RT ANTERIOR AND POSTERIOR TIBIAL ARTERY OCCLUSION TREATED WITH LIMITED FOOT AMPUTATION

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INTRODUCTION:

In cases of diabetic foot ulcer with peripheral vascular disease that is not amendable with a vascular bypass the logical option is usually a major amputation above the level of the vascular blockage.

This is a case report on a non-healing wound post Ray's amputation with right anterior and posterior tibial artery occlusion that was successfully treated with limited foot resection and aggressive wound care management.

CASE REPORT:

A 64-years-old Eurasian man was referred to wound team for non-healing wound post ray's amputation of 4th and 5th toes. A CT Angiogram (CTA) was performed which showed bilateral lower limb atherosclerotic disease with total occlusion of right anterior tibial artery, presence of occlusion at proximal right posterior tibial artery with distal reconstitution. Vascular team was consulted and a below knee amputation was advised.

However, the patient was not keen, and he was referred to the wound team for further management. Examination showed a healthy local wound bed but the 3rd toe was gangrenous. There were no signs of local or systemic infection.

He underwent wound debridement and ray amputation of the 3rd toe. Post-surgery, the wound was cleaned and dressed twice a week using silver nanocolloidal spray and chitosan biopolymer gel. The second toe was also removed after two weeks when the base

of the toe became necrotic and sloughy. The same dressing procedure was done after that. The patient was co-managed with the endocrinology team and blood glucose was monitored closely and kept under tight control.

After the second toe amputation the wound improved tremendously. Post-operative one month, the base was healthy with 100% granulation tissue. The wound shrunk to half its initial size after 2 months and at three months it was almost 90% healed.

Throughout the treatment, the patient was able to walk and was extremely satisfied with his mobility.

DISCUSSIONS:

In majority of diabetic foot ulcers with evidence of peripheral vascular disease that is non-operable, a major amputation is usually the only option considered. However, if there is no signs of systemic infection and local wound conditions are favorable a limited resection may be considered. An aggressive multi-disciplinary approach should be undertaken, and this will aid the healing. Although the wound healing took longer, salvaging the foot gave the patient a better quality of life.

CONCLUSION:

Limited foot resection with aggressive wound care in a diabetic foot ulcer with inoperable peripheral vascular disease may be a viable alternative to major amputation selected cases.