Letter to editor

Clinical practice recommendations for diabetic foot attack

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Dear Editor

I would like to congratulate the Global Wound Care Journal for the publication of the guideline *Clinical Practice Recommendations for Diabetic Foot Attack: This is How We Do It: Guidelines from the Latin American Diabetic Foot Association (ALAPID)*' by Martinez de Jesus et al (2025).

The document is an exhaustive paper on the acute diabetic foot. Rarely did we encounter in the medical diabetic foot literature, such a comprehensive and practical article on a single subject. A diabetic foot attack (DFA) could be a devastating complication of diabetes where it could lead to high rates of amputation and mortality. A neglected diabetic foot ulcer (DFU) could deteriorate in few days into the acute form of osteomyelitis, gangrene or sepsis. The seriousness of DFA has been found to depend not only on patient lack of awareness but also to the lack of urgency among primary physicians too. In fact, late presentation has been considered a risk factor for amputation in patients with diabetic ulcers (Jeffcoate and Harding 2003). A multicentre study in Europe demonstrated that patients' complaints led to diagnosis on 60% of the time, and the remainder of the time this diagnosis was an incidental finding during a consultation 13-28% of the time (Prompers et al, 2008; Manu et al, 2018). Additionally, a delay of DFU diagnosis of more than 3 weeks from the onset of the wound was reported up to 66% of cases (Prompers et al, 2008).

I appraise the authors not only for accurately describing the progressive stages of diabetic foot attack or detailing the clinical details in relation to the assessment of the 10 Saint Elian factors, but also for exposing a rational therapeutic approach using practical algorithms. The guideline reminds us of the important place of early surgical treatment aiming to save limbs and lives. It has been demonstrated that conservative surgery could yield good to excellent surgery with significantly better rates in terms of wound healing, wound recurrence and wound infection when compared to standard of care Yammine and Assi, 2020; Yammine et al, 2022).

To add, the Saint Elian Wound Score System (SEWSS) system offers a preventive model which includes guidelines for referral and counter-referral based on different levels of care. More importantly, the system highlights the necessity to locate and treat the aggravating factors that could impede wound healing categorising those accompanied with or without infection.

The inclusion of diagnostic and therapeutic algorithms in the guidelines, that might seem complex at first glance, are essential to grab the pathways for management. The recommendations for rehabilitation, biomechanics and footwear following surgery are concise and clear for any healthcare provider. More, the methodology used for planning health education interventions is tailored and guided according to the classification and grades of the diabetic foot attack.

The telemedicine (TM) paragraph offers balanced views on the advantages and limitations of this provision of medical care when distance is a concern. A recent meta-analysis showed that TM could be at least as effective as to face-to-face attendance (Yammine and Estephan, 2022).

While the SEWSS has gained popularity around the globe by being arguably the most inclusive wound classification system, this work of Martinez de Jesus et al. showed a great example of marrying an academic classification system such as the SEWSS with effective and practical clinical management.

I believe that this document should not be confined to Latin American doctors but to be on the desktop of every healthcare provider worldwide dealing with wounds and diabetic feet.

Congratulations to the Saint Elian team and to ALAPID for this magnificent work. ●

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