CLI Therapy - LINCed
Multi disciplinary discussions on CLI

Infection and Ischemia
Which Takes Priority???

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Disclosure

Speaker name:

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I have the following potential conflicts of interest to report:

☐ Consulting
☐ Employment in industry
☐ Stockholder of a healthcare company
☐ Owner of a healthcare company
☐ Other(s)

☒ I do not have any potential conflict of interest
World of Today

CLI and diabetes cannot be separated

- WHO projects a 170% growth of diabetes by 2025
- Studies on CLI; 60% diabetes (BASIL trial, PREVENT III)
- Specialized vascular centers 70-80% diabetes
The European Study Group on Diabetes and the Lower Extremity (Eurodiale)

Predictors of Lower-Extremity Amputation in Patients With an infected diabetic foot ulcer

- 575 patients; infected diabetic foot ulcer
- 28% underwent an amputation
Independent risk factors

- periwound edema
- foul smell
- deep ulcer
- pretibial edema
- Fever and elevated C-reactive protein.

The presence of PAOD is an independent risk factor for amputation with an odds ratio of 3.
THE SVS WIfI CLASSIFICATION SYSTEM

limb perfusion, wound depth and presence and extent of infection

- The WIfI is intended to define the disease
- Predicts amputation

Not designed to dictate treatment method
How do you prioritize revascularisation vs. treatment of infection in patients with CLI

No Studies
Infection and oedema compromise the arterial flow
Case 1

- age
- Rest pain
- Dry necrosis
- BTK disease

Courtesy Schreve
Case 1

• Revascularisation
• Amputation
• healing
CASE 2

CLI and diabetes

- Transmetatarsal amputation of the 4th
- Neuro-ischemic ulcer and osteomyelitis of the 5th (WIfI: W1I2fI2)
- Transmetatarsal Amputation 5th
- PTA of the SFA
Guidelines

Culture

- Tissue or bone biopsy
- Swab (deep or Levine technique)

Antibiotics:

- Start empirical
- Severe infections/osteomyelitis $\Rightarrow$ 2 weeks
Case 3

- 65 Male premorbid ambulant
- Diabetes
- Renal Failure on Haemodialysis via AVF
- EF 60%
1st Toe Amputation 1 month ago..defaulted follow up
Clinically Crepitus in Foot suspicious of Necrotizing Fascitis + Impending SIRS

Tachycardia
WBC 25k
25/8/17 Immediate disarticulation and Washout

Tissue Culture = Mixed Growth Enteric Organisms
Intravenous Amoxicillin and Clavalunate
R6 Wound (W3l3fl3)
Necrotizing Fascitis + Impending SIRS
Dialysis dependent

Which Angiosome required?
28/8/17 Debridement + Pulse Lavage
6/9/17 and 13/9/17 **Debridement**
Bone Biopsy = No Growth of Bacteria
20/10/17

Split Skin Graft
27/10/17 came in with wet and infected wounds SSG not taken
"Infection" at forefoot area.
Plantar epithelizing
21/12/17
Pus tracking along plantar and dorsum
Staph Aureus Bacteremia
17/1/18 Formal BKA
Take home message

• Diabetes is not a problem of the future............ *IT IS A PROBLEM NOW!*  
• CLI and diabetes is a common scenario (50% amputation)  
• Infection requires *Aggressive Surgical Debridement*  
• Renal Failure is tricky......
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