

THE FETID FOOT: 2011 RISK MANAGEMENT LECTURE

Speaker



Mickey D. Stapp, DPM – Dr. Stapp graduated from the University of Georgia with a Bachelor of Science degree in Pharmacy. He then earned his Doctorate of Podiatric Medicine from Barry University and completed a three-year residency in foot and ankle surgery at Northlake Regional Medical Center in Atlanta, Georgia. Dr. Stapp is Board Certified in both foot surgery and reconstructive rearfoot/ankle surgery by the American Board of Podiatric Surgery.

He is a Fellow of the American Society of Podiatric Surgeons (ASPS), Fellow of the American College of Foot and Ankle Surgeons (ACFAS), Diplomate of the American Board of Podiatric Surgeon (ABPS), member of the American Podiatric Medical Association (APMA), and member of the Georgia Podiatric Medical Association (GPMA).

Dr. Stapp has served on the board of Directors for the ASPS since 2009. He serves on the board of directors for The Podiatry Institute (PI) and is currently the Vice-Chairman. He is a delegate for the GPMA to the House of Delegates of the APMA. Dr. Stapp has served on several committees for the APMA and the ACFAS. He served on the GPMA board of directors from 2000-2009 and was President of the association from 2006-2008.

Dr. Stapp practices podiatry in Augusta, Georgia and lectures regularly on topics of medicine and surgery of the foot and ankle around the country. He has also authored or co-authored numerous articles for medical journals and chapters in textbooks.

DISCLAIMER

The information presented in this lecture and contained in this document does not establish a standard of care. The information is for general informational purposes to aid in reducing professional liability exposure.

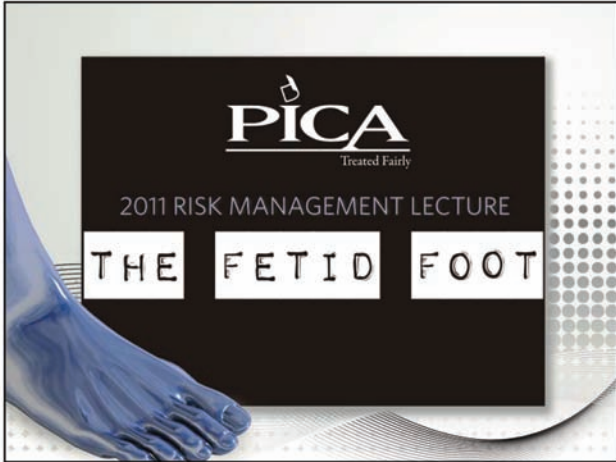


Figure 1.

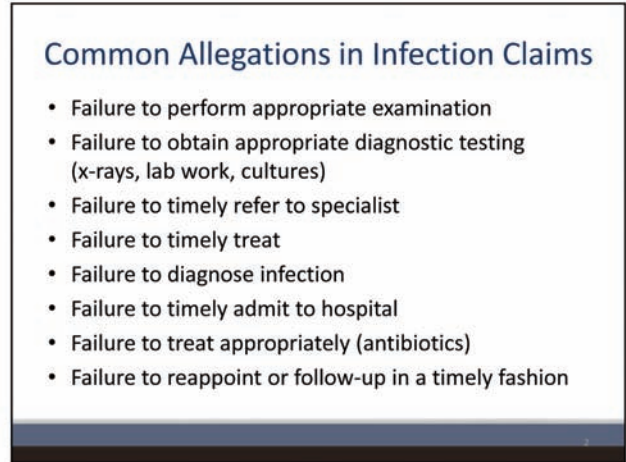


Figure 2.

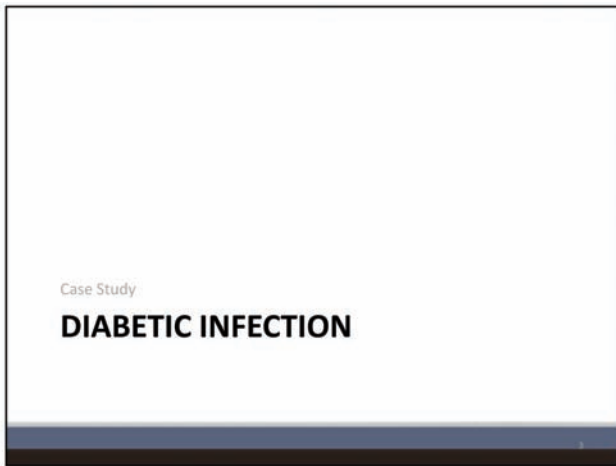


Figure 3.

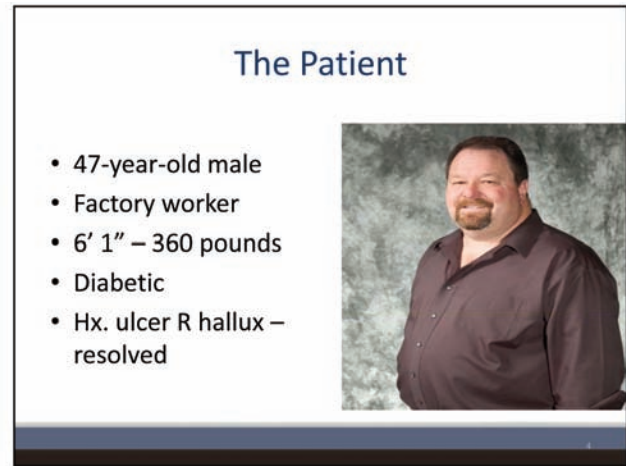


Figure 4.

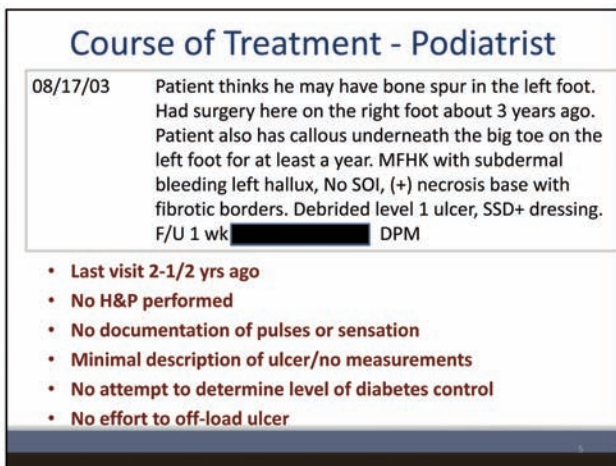


Figure 5.



Figure 6.

8/23/03 Pt in for checkup – pt is in no pain and is happy with the way it's healing. BB
Ulcer non-infected, appears to be resolving. Debrided some fibrotic borders and base to bleeding. F/U 1 week. SSD + dressing with accommodation to insole. [REDACTED] DPM

- Did document accommodation
- Photographs helpful in documentation of wounds

Figure 7.



Figure 8.

8/30/03 Pt in for check on foot he states he is doing well. BB
Ulcer level 1, no SOI, (+) fibrotic material at borders and base, diameter & depth decreasing each visit. Debrided until health bleeding tissue, SSD + dressing. F/U 1 week [REDACTED] DPM

- Size does matter – still no description of size of lesion
- Staging?

Figure 9.

9/06/03 Pt in for check. States no problems. BB
Left hallux ulcer level 1, no SOI, debrided fibrosis and HK, granular, bleeding base, SSD + dressing. F/U 1 week. [REDACTED] DPM

- What is treatment plan?
- What were instructions for home care?
- Is pt. adhering to plan?

Figure 10.

10/29/03 Patient states ulcer on left big toe has been bleeding and has sort of a smell to it but there's no pain. MF
T 96.5 (+) malodor (+) necrosis & fibrous borders (+) drainage No active purulence. Grade 2 ulcer, no bone exposed. Debrided ulcer to bleeding tissue, SSD and Dressing to remove exostosis. Keflex prophyl [REDACTED] DPM

- Pt. was appointed for 1 wk., but did not return until 6 wks. later
- No documented reason why pt. misses appointments.
- Previously described ulcer as "level" – now "grade"
- What is "active" purulence? – doesn't describe drainage
- "Prophyl"?
- SOI – systemic/local
- When should pt. be reappointed?

Figure 11.

11/01/03 No SOI, no pain, some fibrosis present. Debrided to granular tissue, schedule exostosis excision ASAP. [REDACTED] DPM

- Did recheck pt. within 72 hrs. of suspicion of infection
- Surgery scheduled for 11/21/03
- Staff called pt. 11/7/03 to inform him that they obtained the pre-certification for his surgery. Pt. stated he went to his family physician and was told that he had an infection and was given antibiotics
- Pt. never returned

Figure 12.



Figure 13.

Subsequent Treatment - PCP

- 11/6/03
 - c/o swelling L ankle X 2 wks and concerned about blood sugar
 - Noted swelling of L foot & leg
 - Prescribed Augmentin
 - MRI of L foot to r/o osteo scheduled for 11/12
- Pt. did not return

5 days – increase in symptoms of infection

Figure 14.



Figure 15.

Subsequent Treatment - Hospital

- 11/9/03 – to ED
 - Noted L great toe foul smelling & edema of dorsum L foot
 - X-rays neg. for obvious bony abnormality
 - Uncontrolled diabetes
 - Ortho consult
 - Dx = Type 2 diabetes; increasing cellulitis, L foot with associated abscess
 - Recommended surgical I&D
 - Concerned about possible osteo and possible need for amputation
 - MRI – consistent w/osteof of the first distal phalanx

Figure 16.



Figure 17.

- 11/10/03
 - Ortho performed I&D – noted lateral aspect of great toe had wet gangrene w/ malodorous drainage and necrotic tissue; bone consistent with osteo.
 - Cultures taken → pos.
 - Bacteroides uniformis
 - Bacteroides eggerthii
 - Preptostreptococcus species

Figure 18.



Figure 19.

- 11/11/03
 - Inf. Dis. Consult
 - Recommended continued IV Zosyn
- 11/12/03
 - Ortho amputated L great toe
 - Path report consistent with ischemic gangrenous necrosis
- 11/14/03
 - Discharged from hospital on oral Augmentin

Figure 20.



Figure 21.

Post-Op Course

- Followed by ortho
- At last visit, 1 mo. post-op
 - healing well
 - no c/o pain
 - Released to return to work 2 wks. later with no restrictions

Figure 22.

Lawsuit

Allegations against podiatrist

- Negligently performed debridement procedure in an office setting
- Failure to urgently admit the patient to hospital for IV antibiotics and wound care in Aug/Sept 2003

These allegations are defensible, but...

Figure 23.

Problems with Defense

- Failure to perform an appropriate examination
 - No H&P after 2-1/2 yr. lapse
 - No documentation of pulses
 - Minimal description of ulcer
- Failure to obtain appropriate diagnostic testing
 - No attempt to determine level of diabetes control
- Failure to timely refer to specialist
 - No attempt to contact PCP re: treatment of diabetes
- Failure to diagnose infection
- Failure to treat appropriately
 - No effort to off-load ulcer

Figure 24.

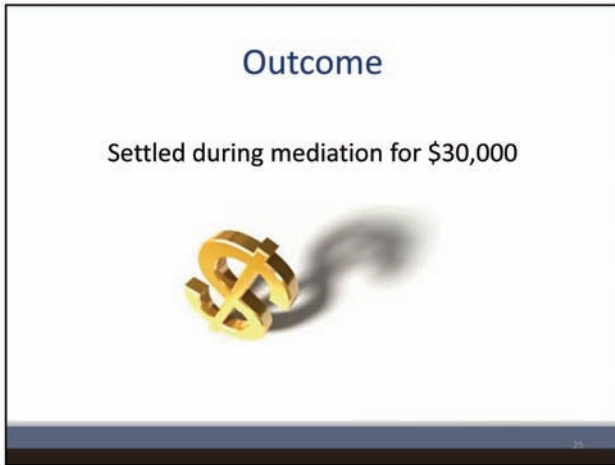


Figure 25.

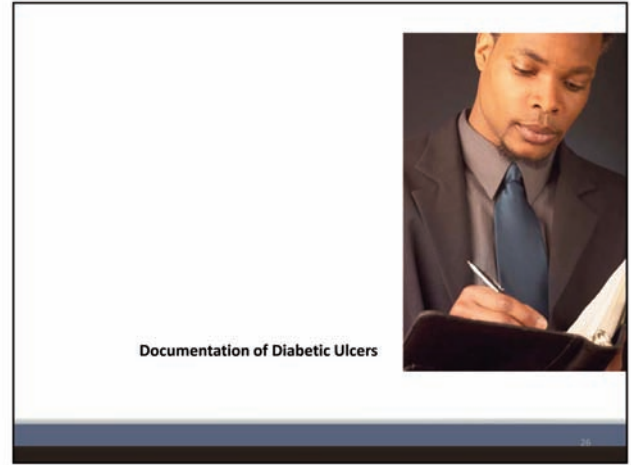


Figure 26.

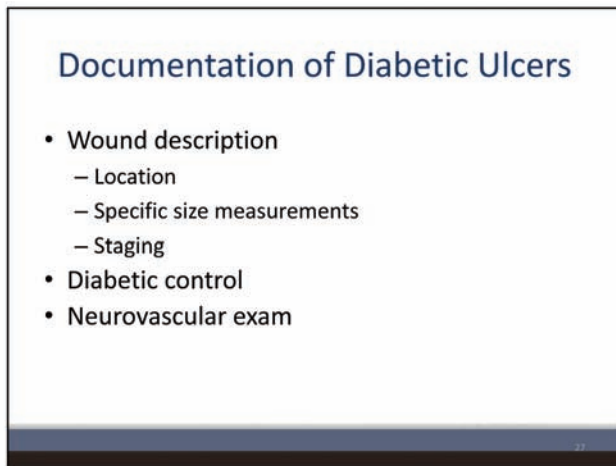


Figure 27.

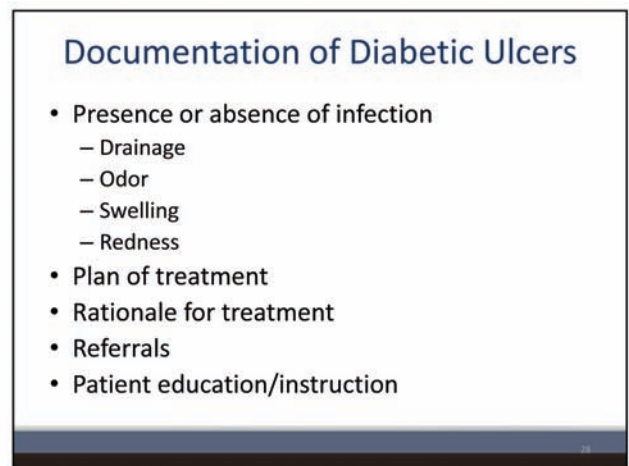


Figure 28.

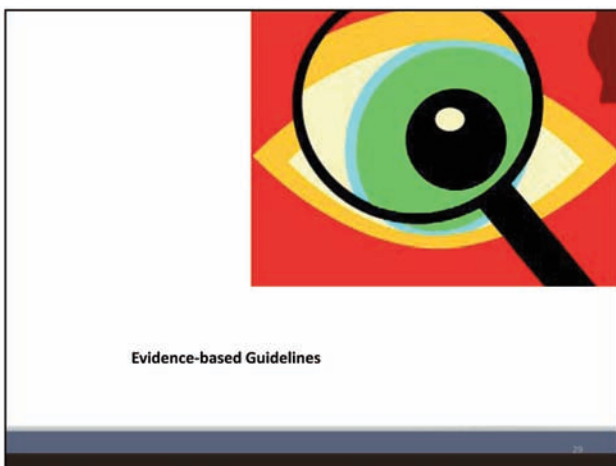


Figure 29.

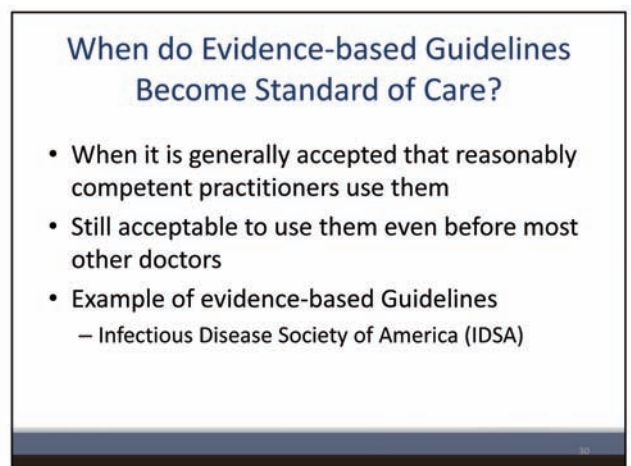


Figure 30.

How do you defend yourself when using evidence-based guidelines that have not yet become SOC?

- Establish that literature supports the guidelines
- Establish the rationale for the guidelines
- Explain why did not use other methods

Figure 31.

How do you defend yourself when using SOC that is contrary to evidence-based guidelines?

- Guidelines are an educational tool – not inflexible rules or requirements of practice
- Not intended to establish SOC
- Ultimate judgment re: specific course of action must be made by physician in light of circumstances
- An approach different from guidelines does not imply breach in SOC – approach may be indicated by circumstances (e.g., condition of pt., limited resources, advances in knowledge subsequent to publication of guidelines, etc.)

Figure 32.

Case Study

POST-OPERATIVE INFECTION

Figure 33.

The Patient

- 62-year-old female
- Supply purchaser for manufacturing company
- Hx. excision of left calcaneal exostosis
- c/o recurrent pain L heel, increasing in severity



Figure 34.

Course of Treatment - Podiatrist

- 11/4/06 – initial evaluation
 - Pt. reported trial of different shoe types and padding → no relief of pain. Requested surgical intervention.
 - Erythema circumferentially around the posterior-superior aspect of L heel.
 - Dorsalis pedis and posterior tibial pulses +2/4 bilat.
 - Patellar and Achilles deep tendon reflexes +2/4 bilat.

Figure 35.

- X-ray, L foot → “hypertrophic bone formation at the posterior and superior aspect of calcaneus. Kager’s triangle is intact and the Achilles tendon appears normal. Increased soft tissue density is noted just posterior to the area of bone hypertrophy.”
- Diagnosis = Left foot retrocalcaneal hypertrophy of bone with pain
- Plan = Left foot retrocalcaneus, osteotomy of bone
- **Surgery scheduled for next day**

Figure 36.

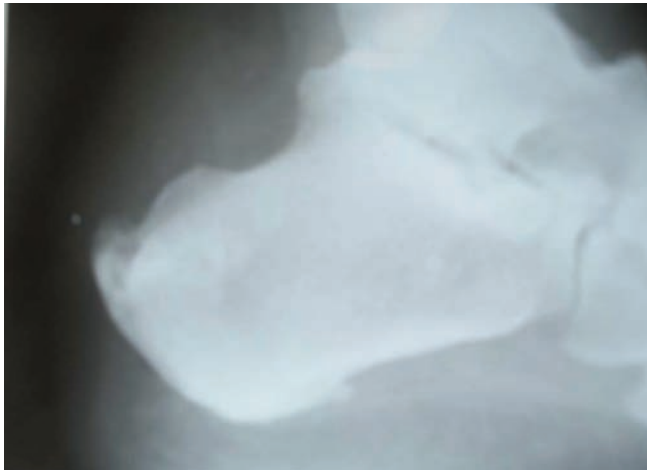


Figure 37.

11/5/06 – Surgery

- Dx: (L) retrocalcaneal hypertrophy of bone
- Procedure: (L) retrocalcaneal partial ostectomy with partial detachment and reattachment of the Achilles tendon with internal fixation
- Pt. tolerated procedure and anesthesia well and left OR with all VSS and good perfusion to the (L) foot.

Figure 38.

11/8/06: 3 days post-op

(S) Pt. presents for Sx F/U of (L) foot – she had discomfort but not unbearable. Are Ibuprofen taken during waking hours?

(O) & (A) Satisfactory progressive post-op healing. Sutures intact. 0 signs of infection.

(P) Sterile lysol scrub done to (L) foot
 X-ray taken (L) foot, DP & LAT – Pt wore lead apron
 X-rays reviewed
 EGS directed to (L) foot @ 300 V x 15 min.
 Sterile dressing with polysporin powder applied to (L) foot
 BK cast applied to (L) foot with Fiberglass material
 Return to office in 5-7 days
 Rx. Cephalexin 500mg. Disp #40 (forty) Take 1 tab. Q6H w/food

- Lysol scrub?
- Why was cephalexin prescribed?

Figure 39.

11/15/06: 1 week 3 days post-op

(S) Pt. presents for F/U of (L) foot Sx. Reports her foot feels good except when it swells. She can feel it tight on the cast

(O) & (A) Satisfactory progressive post-op healing. Cast intact.

(P) Diathermy directed to (L) heel through the cast @ 50% X 15 min.
 Cast checked – cast removed
 Sterile Lysol scrub done to (L) foot
 Sterile dressing with polysporin powder applied to (L) foot Sx.
 Cast reapplied
 Return to office 10 days

- Why diathermy through cast when cast was later removed?

Figure 40.

11/24/06: 2 weeks 5 days post-op

(S) Pt. presents for F/U (L) foot Sx. Reports she only has discomfort when her foot swells

(O) & (A) Satisfactory progressive post-op healing. Sutures intact. Cast intact.

(P) Cast removed
 Sterile Lysol scrub done to (L) foot
 EGS directed to (L) foot @ 200 V X 15 min.
 Surgical site debrided
 Sterile dressing w/polysporin & zinc applied to (L) foot Sx. site
 Cast applied with fiberglass
 Return to office 1 week

- Surgical site debrided, polysporin applied – why?
- Were sutures removed?

Figure 41.

- Pt. returned weekly for next 2 weeks.
- Same documentation, same treatment
- Weight bearing status?
- Home instructions?

Figure 42.

12/16/06: 5 weeks 6 days post-op

(S) Pt. presents for F/U (L) foot Sx. Reports pain.

(O) & (A) Satisfactory progressive post-op healing.

(P) Sterile Lysol scrub done to (L) foot

(L) foot examined

Sterile dressing with polysporin applied to (L) foot Sx site with Desitin

EGS directed to (L) foot @ 200 V x 15 min

Pt advised to take Motrin

Pt advised to wear open-back shoes for right now

Return to office Monday (3 days)

- **Why was polysporin & sterile dsgr. applied at 6 wks. post-op?**
 - Desitin?
- **Why was patient instructed to return in 3 days?**

Figure 43.

12/20/06: 6 weeks 3 days post-op

(S) Pt. presents for (L) foot Sx F/U. Reports no pain.

(O) & (A) Satisfactory progressive post-op healing.

(P) Sterile Lysol scrub done to (L) foot

EGS directed to (L) foot @ 400 V x 15 min

Sterile dressing with Desitin and polysporin applied to (L) foot Sx.

- **“Satisfactory progressive post-op healing”, but still applying dressing**
- **No description of surgical site**

Figure 44.

12/23/06: 6 weeks 6 days post-op

(S) Pt. presents for F/U (L) foot Sx. Reports little pain.

(O) & (A) Satisfactory progressive post-op healing with capsulitis

(P) Sterile Lysol scrub done to (L) foot

EGS directed to (L) foot @ 400 V x 15 min

(L) ft. examined

Sterile dressing with polysporin applied to (L) ft.

Return to office 1 week.

- **Returned 3 days after previous visit – why such frequent visits at almost 7 wks. post-op?**
- **Still applying sterile dressing**

Figure 45.

- Pt. returned weekly for the next 6 weeks
- No documentation of capsulitis, no wound description
- Same treatment
 - Lysol scrub, sterile dsgr., ointment
- Still obvious open wound, but no documentation of such

Figure 46.

2/18/07 • Notes getting better – foot getting worse?

(S) Pt. reports increased drainage from the surgical site for 3-4 days. She also c/o increased pain. She stopped doing the stretching exercises due to the pain.

(O) & (A) (L) retrocalcaneal surgical scar with mild deshiscence of incision. Drainage noted – mild erythema.

(P) (L) foot surgical site cleansed with H2O2.

EGS directed to (L) heel at 200 V x 15 mins.

Wound culture taken (L) heel. Sent to lab.

Pt. to use compresses on heel

To ease off on stretching

Rx Cephalixin 500 mg. Dispense #40 (forty), Take 1 tab. Q6H with food.

RTC 1 wk • **No documentation of systemic systems**

Figure 47.



Figure 48.

- No mention of culture results in subsequent notes
- Pt. returned every 3-4 days for next 4 visits, then weekly for the next 3 weeks.

Figure 49.

4/1/07
 (S) Pt. presents for F/U (L) heel. Reports her heel has been hurting a lot and the wound is open again.
 (O) & (A) S/P (L) heel resection with wound dehiscence.
 (P) EGS directed to (L) heel at 200 V x 15 mins.
 Sterile Lysol scrub done to (L) heel
 (L) heel examined
 Cultures taken – sent to lab
 Pt. should still soak Ft.
 Rx Cipro 500 mg. Disp. #20 (Twenty), Take 1 Tab. BID with food.

- Dehiscence ≠ infection
- Antibiotic changed to Cipro. Why? Was Cephalexin d/c'd?
- Now 5 months post op

Figure 50.

- Pt. seen every 3-4 days for next 3 visits.
- Again, no mention of culture results in notes

4/14/07
 (S) Pt. reports her foot is feeling much better.
 (O) & (A) (L) foot retrocalcaneal suture rejection site is 90% cleared.
 (P) Sterile Lysol scrub
 EGS X 15 min. at 120 V
 Sterile dressing with polysporin and zinc oxide to (L) Ft.
 Rx Septra DS, #20, BID with food.
 RTC 4 days

- Antibiotic changed to Septra. Why?
- Are the Cipro and Cephalexin still being used?

Figure 51.

- Pt. seen every 3-4 days for next 4 visits
- At visit on 5/2/07, the pod advised the patient “of the need for an X-ray to evaluate osseous involvement in recurrence of pain.”

Figure 52.

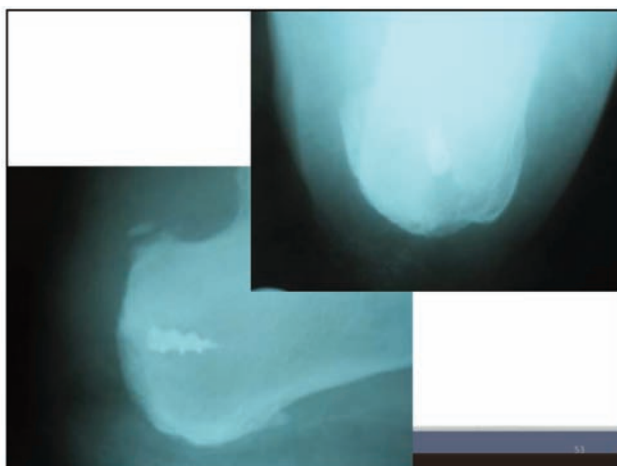


Figure 53.

5/6/07
 (S) Pt. presents for F/U (L) heel – still draining and has “puffy” spot – blister – yesterday was bigger – need Rx for MRI written
 (O) & (A) (L) retrocalcaneal resection.
 (P) Sterile Lysol scrub done
 EGS directed to (L) heel at 250 V x 15 min
 (L) heel examined
 C&S taken (L) ankle. Specimen sent to lab
 Sterile dressing with polysporin to (L) heel
 Rx Cephalexin 500 mg, Disp. #40, Take 1 tab Q 6H with food.
 Rx MRI (L) ankle, 3 mm cuts, without contrast
 RTC 3 days

- Still no description of culture results, but pt. prescribed Cephalexin
- No mention of x-ray results
- No description of wound

Figure 54.

- Pt. returned every 3 days for next 2 visits.

Figure 55.

5/24/07

(S) Pt. presents for F/U (L) heel. Feels a little better

(O) & (A) (L) Ft. retrocalcaneal aspect resection

(P) Sterile Lysol scrub done to (L) Ft.

EGS directed to (L) heel at 200 V x 15 mins.

(L) heel examined

C&S results discussed with Pt. from 05-06-07

C&S taken, Specimen sent to lab.

ID specialist discussed with Pt. if problem persists

Sterile dressing with polysporin to (L) heel

RTC 3 days

- No mention of MRI results
- Discussed culture results, but no mention of what the results were
 - Was antibiotic prescribed?
- Finally thinks of ID consult – was “discussion” enough?

Figure 56.

Returned every 3 – 7 days over the next 2 months

- 6/3/07 - Septra DS ordered
- 6/8/07 - More cultures taken
- 6/15/07 – Pt. reported she saw ID doctor and he started new antibiotic – Zyvox. (ID doctor recommended removal of hardware from heel)
- 6/27/07 – Another culture taken – no mention of results. No acknowledgement of ID doctor’s recommendation to remove hardware.
- 7/11/05 – Another culture taken – no mention of results
 - Chasing cultures
- 7/21/07 - !st mention of systemic symptoms
 - Pt. not admitted. Why?
 - Pt. not following with ID. Why?
- 7/23/07 – Finally sent to hospital

Figure 57.

Subsequent Treatment

- Hospital
 - Hardware removed in the ED
 - Admitted
 - Surgical debridement
 - ID consult
 - Bone cultures + for MRSA
 - IV antibiotics started
- Post Discharge
 - 6 wks. home IV Vancomycin & oral Rifampin

Figure 58.

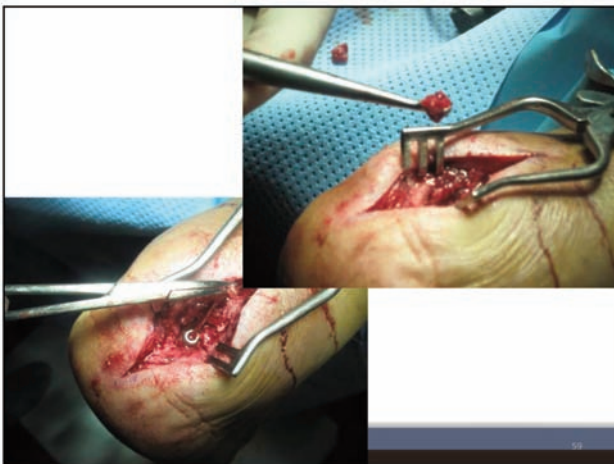


Figure 59.



Figure 60.

Lawsuit

Allegations against podiatrist:

- Negligence in managing post-operative infection
- Failure to prescribe the correct antibiotics
- Failure to refer to a specialist in a timely manner
- Failure to remove the hardware after the infectious disease specialist recommended that it be removed

Figure 61.

Problems with Defense

- Failure to perform appropriate examination
 - No description of wound
 - No rationale for prescribing antibiotics
 - No mention of C&S results in progress notes
 - No rationale for not adhering to ID recommendations
- Failure to timely refer to specialist
- Failure to treat appropriately
 - Multiple cultures were + for MRSA, but was never addressed by podiatrist
 - Did not follow the recommendations of the infectious disease specialist (hardware removal & antibiotic)
 - Infection developed into osteomyelitis

Figure 62.

Outcome

Settled during mediation for \$55,000




Figure 63.

Common Allegations in Infection Claims

- Failure to perform appropriate examination
- Failure to obtain appropriate diagnostic testing (x-rays, lab work, cultures)
- Failure to timely refer to specialist
- Failure to timely treat
- Failure to diagnose infection
- Failure to timely admit to hospital
- Failure to treat appropriately (antibiotics)
- Failure to reappoint or follow-up in a timely fashion

Figure 64.

Ulceration Classification Systems

University of Texas at San Antonio (UTSA) Classification System

| | |
|----------------|---|
| Grade 0 | No open lesions: may have deformity A. Without infection or ischemia B. With infection C. With ischemia D. With infection + ischemia |
| Grade 1 | Superficial wound not involving tendon, capsule or bone A. Without infection or ischemia B. With infection C. With ischemia D. With infection + ischemia |
| Grade 2 | Wound Penetrating to tendon or capsule A. Without infection or ischemia B. With infection C. With ischemia D. With infection + ischemia |
| Grade 3 | Wound penetrating to tendon or capsule A. Without infection or ischemia B. With infection C. With ischemia D. With infection + ischemia |

Clinical Classification of a Diabetic Foot Infection

| Clinical Manifestations of Infection | Infection Severity | PEDIS* grade |
|---|--------------------|--------------|
| Wound lacking purulence or any manifestations of inflammation | Uninfected | 1 |
| Presence of ≥ 2 manifestations of inflammation (purulence, or erythema, pain, tenderness, warmth, or induration), but any cellulitis/erythema extends ≤ 2 cm around the ulcer, and infection is limited to the skin or superficial subcutaneous tissues; no other local complications or systemic illness. | Mild | 2 |
| Infection (as above) in a patient who is systemically well and metabolically stable, but which has ≥ 1 of the following characteristics: cellulitis extending > 2 cm, lymphangitic streaking, spread beneath the superficial fascia, deep-tissue abscess, gangrene, and involvement of muscle, tendon, joint, or bone. | Moderate | 3 |
| Infection in a patient with systemic toxicity or metabolic instability (e.g., fever, chills, tachycardia, hypotension, confusion, vomiting, leukocytosis, acidosis, severe hyperglycemia, or azotemia). | Severe | 4 |

*International Consensus on the Diabetic Foot PEDIS system: perfusion, extent/size, depth/tissue loss, infection, and sensation.

Progress Note Documentation

Each patient encounter should be documented in a consistent format and should accurately capture the essence of the visit. A common, widely accepted method of progress note documentation is the **SOAP** (Subjective, Objective, Assessment, and Plan) method. It is a problem-oriented method of recordkeeping that provides a structure in which to organize a large amount of information. These records are easy to review if kept properly, and reduce the potential for overlooking a problem.

Subjective component

The subjective component is the information relevant to the current visit you obtain by talking to the patient, family members, or friends. Subjective documentation includes:

- An introductory statement summarizing a description of the patient, the main reason for the visit/chief complaint (the patient can be quoted);
- Past medical history, family history, systems review, social history, and risk factors;
- History of present illness, including onset, location, duration, character (sharp, dull, radiating), alleviating/aggravating factors, temporal pattern (every morning, all day, at night, etc.);
- The patient's view of the cause of the problem;
- Home remedies the patient has tried;
- Any other medical treatment the patient has received for the problem; and
- Current medications and allergies.

Any new problems or complaints should also be listed here.

Objective component

The objective component is measurable and observable information that you obtain during the visit. Objective documentation includes:

- Your observations (bandage dirty/wet, patient is crying, etc.);
- Physical examination findings (include pertinent positive and negative findings);
- Laboratory data (include pertinent positive and negative findings);
- Vital signs;
- Measurements (size of a wound, IM angle, induration);
- Descriptions (lesions, wounds);
- Results of diagnostic tests; and
- Any complications or unexpected outcomes.

Assessment component

The assessment component is your interpretation/assessment of subjective and objective findings of the patient's condition/problem or level of progress. The assessment determines whether the problem has been resolved or if further care is required. Assessment documentation includes:

- Identification of each active problem (list individually with a corresponding number – this list should correspond to your “problem list” maintained at the front of the medical record);
- The diagnosis or differential for each problem;
- The evidence/rationale for your assessment;

- Physical/social implications (non-ambulatory status, time off from work);
- Severity and urgency of each problem;
- Prognosis with and without treatment;
- Progress with current treatment; and
- Complicating factors.

Plan component

The plan component is your specific plan for treatment of the patient and the rationale for your plan. For each active problem listed, plan documentation includes:

- Discussion of diagnosis/differential diagnosis with the patient and treatment options;
- Diagnostic studies, tests, and/or consultations ordered;
- Therapy/medications ordered;
- Patient education and instructions (advice, return appointments, what to do if symptoms worsen);
- Goals of care; and
- Expected duration of treatment.

Unresolved problems from previous visits should be addressed in subsequent visits. If the patient is not progressing as expected, reassess and document any change in the treatment plan.

An Example

The following is an example of SOAP documentation for a patient presenting for follow-up of a diabetic ulcer.

5/27/10 – 9:30 a.m.

S: Pt. returns today for follow-up of Grade II ulcer at the 3rd MPJ, L foot. Pt. reports new onset of drainage from L foot ulcer - began 2 days ago – pt. can't relate to any contributing factor. Pt. "changing the bandage every day." Pt. states he checks his blood sugar daily and "it runs in the 100's." He stated he last saw his PCP 2 months ago.

O: Vascular exam = Posterior tibial pulse R foot & Dorsalis pedis pulses, bilaterally are weakly palpable; Posterior tibial pulse L foot is non-palpable. Capillary filling time = < 3 sec X 10. Bilat. feet cool to touch. Neuro exam = sharp, dull, and light touch are all diminished, bilat. feet. Decreased plantar protective sensation, bilat. Pt. has positive hx. of paresthesias. ROM is unchanged; muscle strength is unchanged. Dermatological exam = bluish discoloration of the skin; skin dry, cracked, and peeling; and loss of hair, bilat. Wagner Grade II ulcer sub MPJ#3, L foot measuring 0.5 X 0.5 cm with probing to subcutaneous tissue, but not bone, with mild active clear drainage with no odor or redness. No edema, bilat. Pt. has thickened, dystrophic nails with subungual debris.

A:

- 1) NIDDM w/peripheral neuropathy, stable – PCP following
- 2) Diminished pulses, bilateral – needs referral to vascular specialist for further evaluation
- 3) Distal onychomycosis, ongoing – receives quarterly nail debridements.
- 4) Grade II ulcer, L foot, not improving – off-loading will be necessary to improve healing. Vascular referral as stated in #2. Prognosis is guarded.
- 5) Drainage from L foot ulcer – no clinical signs of infection, needs to be monitored.

- P:**
- 1) Encouraged pt. to keep follow-up appointments with PCP to monitor diabetes.
 - 2) Pt. to see Dr. John Doe for vascular workup. Appt. scheduled for 2:00 p.m. tomorrow. Will review consultation report with pt. at next visit in one week.
 - 3) Patient to return in one month for regularly scheduled nail debridements.
 - 4) Obtained informed consent from pt. for ulcer debridement. Performed sharp debridement of ulcer, full thickness skin & subq. tissue. Hyperkeratotic & devitalized tissue was removed to a clean, bleeding base. Antibiotic ointment, dispersion padding, and dry sterile dressing applied. Instructed pt. to continue daily dressing changes; not to bear any weight on the left foot; and to return for a recheck in one week or sooner if condition worsens. Crutches dispensed to pt and crutch training provided. Pt. demonstrated ability to appropriately walk and go up and down stairs with crutches.
 - 5) Will continue to monitor L foot ulcer for signs/symptoms of infection.

Resources

- ❖ Handbook of Lower Extremity Infections, Third Edition by Warren S. Joseph
- ❖ Evidence-based Guidelines:
 - Infectious Diseases Society of America (IDSA) – www.idsociety.org
 - National Guideline Clearinghouse – www.guidelines.gov
 - American College of Foot and Ankle Surgeons (ACFAS) – www.acfas.org

Risk Management Committee

Marc D. Lenet, DPM, Chairman
 Dennis R. Frisch, DPM
 Jerauld D. Ferritto, Jr., DPM
 Kimberly Eickmeier, DPM
 Robin Ross, DPM
 Timothy Tillo, DPM
 John V. Guiliana, DPM

Director of Risk Management

Barbara Bellione, RN, CPHRM, ARM
 (800) 251-5727, ext. 2052
bbellione@picagroup.com

Claims Department Toll-free Numbers

Phone: (888) 444-7422
 Fax: (888) 329-7422



Podiatry Insurance Company of America
 3000 Meridian Boulevard, Suite 400
 Franklin, TN 37067

www.picagroup.com