Editor's comment

The diabetic foot

BRIDGET FARHAM
ugqirha@iafrica.com

Many years ago – I can't remember whether as a student or an intern – I was at an outpatient clinic for Immelman firm at Groote Schuur Hospital. At the time Ed Immelman was one of the foremost vascular surgeons in Cape Town, so his outpatient clinics were full of diabetics. An older black man was accompanied into the room by his son – along with a smell that made sitting in the confined space difficult. The old man eased his foot out of his shoe. The entire foot was black, wet and smelly. It didn't seem to be particularly painful, but both the son and the patient were obviously very worried about the appearance of the foot. I remember wondering just how the man and his family had left it so long to go to the doctor. I presume this catastrophe, which resulted in a below-knee amputation, had started with the classic problems associated with the diabetic foot. I have no idea whether or not the man was under the care of a GP or a day hospital in his area – I hope not, because if he was, someone had been grossly negligent.

However, I thought that then. About 18 months ago I was alerted to the fact that my father was not well. People had left messages on my phone that he had been taken home because he seemed to be rather confused. My father is a long-standing type 2 diabetic. By this time it was late at night and we had been out to supper with friends – ironically just around the corner from where my father was living at the time! I phoned him – he was completely confused and talking rubbish. We got into the car and drove all the way back into town. By the time we got to his flat he was lucid, but cold, clammy and obviously unwell. It turned out that he was septicaemic as a result of an infected, gangrenous middle toe. This was successfully amputated, by one of the authors in this edition of *CME*, who was also instrumental in sending him to the correct people to deal with the chronic ulcer he had on his great toe on the opposite foot, so avoiding another, and more serious, amputation.

Was anyone at fault in my father's case? I know his GP well – we were at medical school together and I know that he is a caring, competent and conscientious doctor. He didn't pick up the gangrene. My father was not seeing a chiropodist or podiatrist at all – he was still living independently. He couldn't see the underside of his foot, which is where the gangrene was obvious. My father is an educated man with reasonable resources at his disposal – and he landed up with an, albeit small, amputation. This makes the disease progression in the old man from the townships all the more understandable – and also strongly emphasises the importance of regular follow-up for diabetics and just how important regular foot examinations are.

I have no doubt that the below-knee amputation that the old black man suffered as a result of his diabetes totally changed his, and possibly his family's, life. My father's toe amputation was the beginning of the end of completely independent living for him. He moved from his flat into an old-age home a few months after leaving hospital – not really because he could no longer look after himself, but because it became obvious that the time was approaching when he should be in a sheltered environment. This also emphasises the importance of excellent care of the diabetic and the potentially catastrophic consequences of poor foot care. Hence my request to John Robbs for a complete issue on the topic. I hope that it will help to prevent many amputations.

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Tel. (021) 681-7200 Fax (021) 685-1395 E-mail: publishing@hmpg.co.za
Head Office: PO Box 74789, Lynnwood Ridge, 0040. Tel. (012) 481-2000 Fax (012) 481-2100
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