14th & 15th October 2025
Kings Place, London

Awarded 12 CPD hours by RCSEd

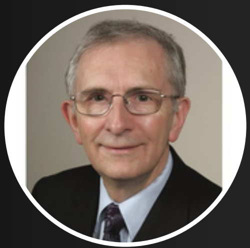
11TH KING'S INTERNATIONAL SUMMIT

on Modern Surgical Reconstruction and Multidisciplinary Care of The Diabetic Foot

Breaking the Chains of the Diabetes Amputation Crisis

Do you treat patients with diabetic foot conditions and want to drive real change?

JOIN US IN THE FIGHT AGAINST MAJOR AMPUTATIONS IN DIABETIC FOOT MANAGEMENT



PROFESSOR MIKE EDMONDS
Co-director

PROFESSOR VENU KAVARTHAPU
Co-director

MEETING CONVENORS:

Dave Russell, Vascular Surgeon, Leeds Teaching Hospital NHS Trust.
Hani Slim, Vascular Surgeon, King's College Hospital.
James Chan, Plastic Surgeon, Stoke Mandeville Hospital.
Asmat Din, Plastic Surgeon, King's College Hospital.
Dane K. Wukich, Foot and Ankle Surgeon, UT Southwestern School of Health Professions
Ngwe Phyo, Consultant Orthopaedic Surgeon, Frimley Health NHS Trust.
Chris Manu, Consultant Endocrinologist, King's College Hospital.
Maureen Bates, Chief Podiatrist, King's College Hospital.

Calling all **Surgeons**, **Radiologists**, **Physicians**, **Podiatrists**, and **Allied Health Professionals** with an interest in MDT diabetic foot care.

www.kdfsummit.com

11th King's International Summit

Modern Surgical Reconstruction and Multidisciplinary Care of the Diabetic Foot

14th & 15th October 2025 | **Kings Place,** London

KEYNOTE SPEAKERS

PROF. DR. DAVID ARMSTRONG
USA

PROF. ANDREW BOULTON
UK

ROBERT CLAYTON
UK

PROF. FRANCES GAME
UK

HONDA HSU
Taiwan

COLETTE MARSHALL
UK

DR. FERMIN MARTINEZ DE JESUS
Mexico

PROF. JOSEPH L. MILLS
USA

DR. MADHU PERIASAMY
India

MAMTA SHETTYVAIDYA
UK

PROF. DR. HAKAN UNCU
Turkiye

DANE K. WUKICH
USA

FACULTY

ANGIE ABBOTT – Torquay

NICOLE ABDUL – Leeds

NASEER AHMAD – Manchester

MAUREEN BATES – London

AILEEN BOYD – London

JONATHAN BOYLE – Cambridge

RANJEET BRAR – London

JAMES CHAN – London

PATRICK CHONG – Surrey

VERITY CURRALL – Bedfordshire

ASMAT DIN – London

PROF. MIKE EDMONDS – London

MARTIN FOX – Manchester

BEN FREEDMAN – London

RAGHVINDER GAMBHIR – London

JAS GIDDIE – London

TOM HESTER – London

DEAN HUANG – London

PROF. VENU KAVARTHAPU – London

IRIS KWOK – London

PATRICIA LEE – London

CHRIS MANU – London

LISA MEACOCK – London

OMAR MUSTAFA – London

ED FITZGERALD O'CONNOR – London

RICHARD PAISEY – Devon

CHRIS PANKHURST – London

TIM PARKINSON – London

AMIT PATEL – London

NINA PETROVA – London

PROF. ARUN PHERWANI – Newcastle

NGWE PHYO – London

SULTAN QASIM – Newcastle

PROF. DR. GERRY RAYMAN – Ipswich

JAYNE ROBBIE – Birmingham

DAVID RUSSELL – Leeds

SRINIVAS SESHABHATTARU – Hyderabad, India

KANISHK SHAH – London

REBECCA SHIRLEY – London

HANI SLIM – London

MICHELLE STAFFORD – London

WEGIN TANG – London

MADHU TIRUVEEDHULA – Basildon

ERIKA VAINIERI – London

DOMENICO VALENTI – London

PRASHANTH VAS – London

NIJIL VASUKUTTY – Lincoln

ALEX WEE – London

MATT WELCK – London

JASON WILKINS – London

HANY ZAYED – London

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TWO2 Therapy Now Available via NHS Supply Chain Advanced Wound Care Framework

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O_2

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Clinical outcomes of diabetic foot osteomyelitis surgeries that include CERAMENT G and CERAMENT V

Retrospective study comparing local antibiotic using CERAMENT G or CERAMENT V therapy vs current standard of care without local antibiotic therapy[1]	Single-stage procedure including debridement and using CERAMENT G or CERAMENT V[2]	The Silo technique for midfoot and hindfoot and intramedullary retrograde filling for the forefoot[3]
Diabetic foot osteomyelitis *56 patients treated with local antibiotic* *49 received standard of care without local antibiotic*	*Diabetic foot osteomyelitis* *103 patients*	*Diabetic foot osteomyelitis* *47 patients*
Mean follow-up time: 14 months	Min. follow-up time: 12 moths	Mean follow-up time: 33 month
87,5% survival rate	**89%** infection-free	**88%** infection eradication
98% did not have a major amputation	**98%** did not have a major amputation	**94%** limb salvage

[1] Metaoy et al. 'Adjuvant local antibiotic therapy in the management of diabetic foot osteomyelitis.' Clinical Diabetes and Endocrinology 2024 10:51
[2] Chow et al. 'Definitive single-stage surgery for treating diabetic foot osteomyelitis: a protocolized pathway including antibiotic bone graft substitute use.' ANZ J Surg. 2024 May 17.
[3] Vasukutty et al. 'Limb salvage surgery in diabetic foot infection: encouraging early results with a local antibiotic carrier.' The Diabetic Foot Journal. 2022;25(2):1–5.

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PR-01599-01 en CE 09-2025

11th KING'S INTERNATIONAL SUMMIT

Symposium

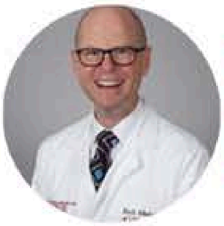
Clinical Experiences in Diabetic Foot Ulcers with a Novel, Multimodal, Nitric Oxide-Generating Wound Dressing

Wednesday, **15th October** 2025 | **13.30-14.00** (BST) | **St. Pancras Room**

Chair

Prof Mike Edmonds, MD, FRCP
Diabetic Foot Clinic, King's College Hospital NHS Trust, London

Presentation



Prof David Armstrong, DPM, PhD
Keck School of Medicine, University of Southern California, Los Angeles

Ms Maureen Bates
Podiatrist, Diabetic Foot Clinic, King's College Hospital NHS Trust, London

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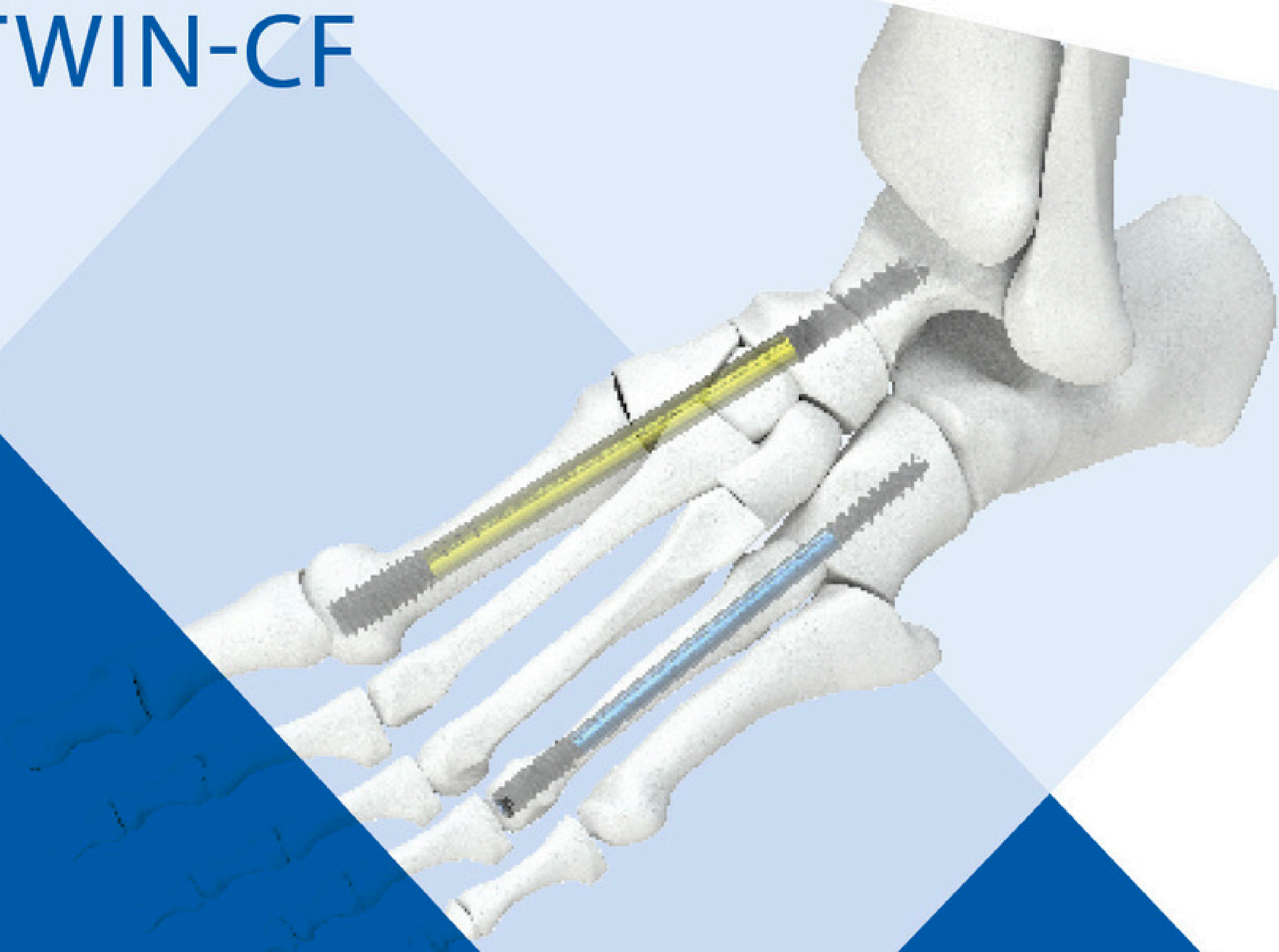

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Screw System

The TWIN-CF Screw System offers a wide range of applications due to the two sizes Ø 7.5 mm and Ø 5.0 mm. Both sizes are available as stabilization and compression screws.

TWIN-CF Stabilization Screw
Cannulated screw for individual compression
The stabilization screw can be used to generate stepless compression via the instrument set. The compressed state is stabilized via the screw.

TWIN-CF Compression Screw
Cannulated screw for automatic compression
The two different thread pitches at the proximal and distal ends provide compression directly when the screw is inserted.


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STIMULAN®
The only calcium matrix antibiotic carrier for use in bone and soft tissue
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An innovative, versatile calcium compound that supports natural healing, then vanishes without a trace.
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Preformed, antibiotic loaded hip, knee and shoulder spacers to maintain space and aid the treatment of infection.
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MA0418RI

Diabetes-related amputations are spiralling out of control, leaving patients to bear
life-altering consequences and health systems to shoulder staggering costs.

THE HARSH REALITY?
Where you live and how much you earn could determine whether you keep your leg or lose it.

In England alone, there's a postcode lottery with nearly a fivefold difference in major amputation rates, hitting hardest in socio-economically deprived areas.

AMPUTATIONS ARE NOT INEVITABLE - THEY ARE PREVENTABLE.
Why are we still letting geography dictate outcomes?

THE 11TH KING'S INTERNATIONAL SUMMIT WILL CONFRONT THIS CRISIS HEAD-ON.

We will challenge outdated approaches and shine a spotlight on the best podiatric and multidisciplinary diabetic foot care along with modern Orthopaedic, Vascular and Plastic Surgical reconstruction techniques that are saving limbs and lives.

Tuesday 14th October

08:00 REGISTRATION

SESSION 1: HOW TO TACKLE THE AMPUTATION CRISIS (Hall One)

Chairs: Venu Kavarthapu and Mike Edmonds

08.30-08.40 Welcome Address **Colette Marshall, Chief Executive Officer, Diabetes UK and Mamta Shettyvaidya, Chief Medical Officer, King's College Hospital**
08.40-08.50 Towards Zero Preventable Amputations! **Mike Edmonds**
08.50-09.05 Reducing Avoidable Diabetic Amputations Through Getting It Right First Time (GIRFT) **Gerry Rayman**
09.05-09.15 Breaking the Cycle of Diabetic Deformity and Limb Loss **Venu Kavarthapu**
09.15-09.25 Limb Saving Soft Tissue Reconstruction of Diabetic Foot **James Chan**
09.25-09.35 Offloading and Expert Wound Care Prevent Amputations **Maureen Bates**
09.35-09.50 Lessons Learnt from the "National Vascular Registry" **Arun Pherwani**
09.50-10.00 Discussion

10:00 COFFEE | INDUSTRY EXHIBITION | POSTERS (Gallery level)

SESSION 2: INFECTION AND SOFT TISSUE LOSS (Hall One)

Chairs: Raghvinder Gambhir and Ranjeet Brar

10.30-11.00 **AOTI INDUSTRY SYMPOSIUM**
10.30-10.40 The Evidence Base and Science Behind Multimodality TWO_2 therapy **Mike Griffiths**
10.40-10.50 The King's Clinical Experience with TWO_2 therapy **Chris Manu**
10.50-11.00 TWO_2 therapy: Within and Beyond Clinical Trial Data (with a patient perspective) **Mike Pierides**

11.00-11.10 Infection, the Great Destroyer of the Diabetic Foot **Erika Vainieri**
11.10-11.20 When to Use IV Therapy and the Value of Outpatient Parenteral Antibiotic Therapy (OPAT) **Aileen Boyd**
11.20-11.30 Osteomyelitis Debridement Principles and Techniques **Ngwe Phyo**
11.30-11.45 **KEYNOTE:** Reducing Mortality from Diabetic Foot Infected Mixed Attack **Fermin Martinez de Jesus**
11.45-11.55 Soft Tissue Cover Post-Debridement Defects **Asmat Din**
11.55-12.05 Discussion

12.05-12.35 **BONESUPPORT INDUSTRY SYMPOSIUM**

CERAMENT® in Diabetic Foot Osteomyelitis - Concepts and usage
CERAMENT® is best partner in management of complex diabetic foot reconstruction and osteomyelitis. It brings injectable technology and resorbing at the same rate as natural bone formation. CERAMENT G and CERAMENT V provide safe and reliable local elution of antibiotics thus protecting bone voids against colonization with a broad range of bacteria.

12.05-12.20 CERAMENT in complex Charcot foot reconstructions – Concepts and usage **Venu Kavarthapu**

12.20-12.35 CERAMENT usage in diabetic foot reconstruction – Plastics perspective **James Chan**

Tuesday 14th October

12:35 LUNCH | INDUSTRY EXHIBITION | POSTERS (Gallery level)

SESSION 3: NEUROPATHY, VASCULAR AND DEFORMITY
(Hall One) **Chairs: Domenico Valenti and Patrick Chong**

13.20-13.40 **KEYNOTE:** Can Peripheral Neuropathy be Cured? **Andrew Boulton**
13.40-13.50 Basics and Advances in Vascular Assessment of Diabetic Foot **Hakan Uncu**
13.50-14.00 Endovascular or Bypass Route in Below-the-Ankle Disease **David Russell**
14.00-14.10 New Approaches to the 'MINOR' Approach **Hani Slim**
14.10-14.20 Advances in Imaging the Charcot Foot **Nina Petrova**
14.20-14.30 Virtual National MDT for Charcot Foot - a New Approach **Nicole Abdul**
14.30-14.40 Discussion
14.40-14.55 **GUEST LECTURE:** BOFAS Presidential Lecture **Robert Clayton**

14:55 TEA | INDUSTRY EXHIBITION | POSTERS (Gallery level)

SESSION 4: PAST, PRESENT AND THE FUTURE
(Hall One) **Chairs: Hakan Uncu and Dane Wukich**

15.25-15.40 **GUEST LECTURE:** Lessons from the National Diabetic Foot Audit (NDFA) **Frances Game**
15.40-16.00 **KEYNOTE:** The Rising Tide of DFUs: It's Time to Stop Mending Dikes and Start Building Durable Bridges and Flow Management **Joe Mills**
16.00-16.20 **KEYNOTE:** Breaking the Chain of Diabetic Amputations **David Armstrong**

SESSION 4A: FREE PAPER PRESENTATIONS
(Hall One) **Chairs: Nina Petrova and Erika Vainieri**

16.20-17.15 Please refer to full abstracts at the end of this programme
5 minutes presentation followed by 1 minute discussion

SESSION 4B: PAST, PRESENT AND THE FUTURE
(Hall One) **Chairs: Mike Edmonds and Venu Kavarthapu**

17.15-17.30 Panel Review of Past, Present and a Peak into The Future of Charcot Foot
Prashanth Vas, Hani Slim, Ngwe Phyo
vs.
Mike Edmonds, David Russell, Venu Kavarthapu

17.30 **CLOSE OF DAY ONE**

17:30-18.15 NETWORKING DRINKS RECEPTION (Gallery level)

Wednesday 15th October

08:00 REGISTRATION

SESSION 5: FREE PAPER & ORAL POSTER PRESENTATIONS (Hall One)

Chairs: Nina Petrova and Ngwe Phyo

08.30-09.30 Free paper and Oral poster presentations
Please refer to full abstracts at the end of this programme
Free papers: 5 minutes presentation followed by 1 minute discussion
Oral posters: 1 minute presentation followed by 1 minute discussion

SESSION 6: DEVELOPING DIABETIC FOOT ORTHOPAEDIC SERVICE LOCALLY (Hall One)

Chairs: Iris Kwok and Amit Patel

09.35-09.45 How I Manage Non-Ulcerated Charcot Foot Deformities **Jas Giddie**
09.45-09.55 How I Established Diabetic Foot Infection Surgery Service **Nijil Vasukutty**
09.55-10.05 A Step Ladder Approach to Training for Diabetic Foot Surgery **Verity Currall**
10.05-10.15 Selecting the Right Charcot Deformity for a Reconstruction **Madhu Tiruveedhula**
10.15-10.25 When We Recommend Prior Vascular Correction Before Reconstruction **Hani Slim**
10.25-10.35 Training Future Diabetic Foot and Ankle Surgeons in USA **Dane Wukich**
10.35-10.45 Discussion

PARALLEL SESSION 1 PODIATRY & MEDICAL: DIABETIC FOOT IMAGING AND WORKSHOP (St. Pancras Room)

Chairs: Wegin Tang and Michelle Stafford

09.40-09.55 Is This Foot Presentation a Charcot, Infection or Gout? **Maureen Bates**
09.55-10.05 The Use of Duplex to Image Ultra Distal Arteries **Ben Freedman**
10.05-10.30 Basics of Interpretation of Diabetic Foot Imaging and Workshop **Lisa Meacock**
10.30-10.45 Discussion

PARALLEL SESSION 2 VASCULAR & PLASTIC SURGERY: BEST PRACTICE APPROACH TO DIABETIC ISCHAEMIC LIMB REVASCULARISATION (Gallery Room)

Chairs: Mike Edmonds and Hakan Uncu

09.40-09.55 Imaging of Distal Arteries with Angio, CT and MRI **Dean Huang**
09.55-10.10 Distal Endovascularisation Techniques and Tips **Jason Wilkins**
10.10-10.20 Has Basil and Best CLI Altered Vascular Practice? **David Russell**
10.20-10.30 Current Orthopaedic Trends in Ischemic Charcot Reconstruction **Tom Hester**
10.30-10.45 Discussion

10:45 COFFEE | INDUSTRY EXHIBITION | POSTERS (Gallery level)

Wednesday 15th October

SESSION 7: GETTING BASICS RIGHT IN CHARCOT FOOT RECONSTRUCTIONS (Hall One)

Chairs: Tom Hester and Kanishk Shah

11.15-11.30 My Approach to Antibiotic Management in Diabetic Foot Surgery **Chris Manu**
11.30-11.40 My Surgical Planning for Midfoot Charcot Reconstruction **Alex Wee**
11.40-11.50 Getting Predictable Outcomes with Hindfoot Reconstruction **Ngwe Phyo**
11.50-12.05 When and Why, I Use Combined Internal and External Fixation? **Madhu Tiruveedhula**
12.05-12.15 Discussion

12.15-12.45 **MARQUARDT INDUSTRY SYMPOSIUM**
Current concepts in midfoot Charcot reconstruction

12.15-12.25 **Venu Kavarthapu** Kings College Hospital
12.25-12.35 **Madhu Tiruveedhula** Basildon University Hospital
12.35-12.45 **Alex Melhorn** Schoen Klinic, Munich

PARALLEL SESSION 3 PODIATRIC & MEDICAL: INTERVENTIONAL SYMPOSIUM AND OFFLOADING WORKSHOP (St. Pancras Room)

Chairs: Erika Vainieri and Prashanth Vas

11.15-11.30 How to Apply a Modified TCC **Wegin Tang**
11.30-11.50 Common Podiatric Surgical Procedures in Practice **Srinivas Seshabhattaru**
11.50-12.05 When and How to Perform a Percutaneous Tenotomy **Patricia Lee**
12.05-12.15 Is the Doppler a Valuable "Piece of Kit" **Chris Manu**
12.15-12.35 How to Carry out a Bone Biopsy **Prashanth Vas**
12.35-12.45 Discussion

PARALLEL SESSION 4 VASCULAR & PLASTIC SURGERY: CREATIVE WAYS OF IMPROVING VASCULAR AND PLASTIC SERVICES (Gallery Room)

Chairs: David Russell and Mike Edmonds

11.15-11.30 Centralisation of Vascular Surgery - The Way Forward **Jonathan Boyle**
11.30-11.40 Admission Avoidance Minor Diabetic Foot Surgeries **Tim Parkinson**
11.40-11.50 An Approach to No-option Ischaemia **Hani Slim**
11.50-12.10 Combined Endovascular and Free Flap Diabetic Foot Salvage **Honda Hsu**
12.10-12.20 Plastic Surgical Reconstruction within an established Diabetic Foot Practice - the King's Experience **Asmat Din**
12.20-12.35 Preventing Secondary Deformity During Soft Tissue Reconstruction **Ed Fitzgerald O'Connor**
12.35-12.45 Discussion

Wednesday 15th October

12:45 LUNCH | INDUSTRY EXHIBITION | POSTERS (Gallery level)

SESSION 8: COMPLEX DIABETIC FOOT SURGERY
(Hall One) **Chairs: Dane Wukich and Srinivas Seshabhattaru**

13.30-14.00 **ORTHOFIX INDUSTRY SYMPOSIUM**

TL-Elevate™ - Innovating in Diabetic Foot Management
TL-Elevate™ - The Strength of Tradition, the Innovation of Regeneration.
Transverse Bone Transport is an emerging surgical technique designed to stimulate neovascularisation, improve regional microcirculation, and promote wound healing in patients unresponsive to conventional treatments.

13:30-13:45 The concept and history of Transverse Bone Transport and why TL-Elevate™ was developed **Alex Cherkashin**
13:45-14:00 The UK experience of TL-Elevate™ for TBT **Simon Chambers**

14.00-14.15 Why do I Choose External Fixation for Reconstructions? **Sultan Qasim**
14.15-14.25 How Do I Manage Infected Charcot Foot Deformities? **Tom Hester**
14.25-14.40 My Approach to Neuropathic Diabetic Foot Deformities **Matt Welck (virtual)**
14.40-14.55 My Approach to Combined Hindfoot and Midfoot Deformities **Venu Kavarthapu**
14.55-15.05 Discussion

PARALLEL SESSION 5 PODIATRIC & MEDICAL:
EXTENDED ROLE OF THE PODIATRIST
(St. Pancras Room) **Chairs: Maureen Bates and Chris Manu**

13.30-14.00 **CONVATEC INDUSTRY SYMPOSIUM**
Clinical Experiences in Diabetic Foot Ulcers with a Novel, Multimodal, Nitric Oxide - Generating Wound Dressing.
Prof Edmonds will outline the need for better healing outcomes in treating DFUs. Prof Armstrong will present emerging therapies, diagnosis, and the clinical evidence accompanying them. Ms Bates will detail the first clinical experiences at King's College of a new, multimodal, nitric oxide-generating device. Prof Edmonds will reflect on this innovation and open the floor for questions.

13.30-13.35 Opening **Mike Edmonds**
13.35-13.45 New therapies for DFUs **David Armstrong**
13.45-13.55 First clinical experiences **Maureen Bates**
13.55-14.00 Final remarks and questions **Mike Edmonds**

Wednesday 15th October

PARALLEL SESSION 5 PODIATRIC & MEDICAL:
EXTENDED ROLE OF THE PODIATRIST
(St. Pancras Room) **Chairs: Maureen Bates and Chris Manu**

14.00-14.15 ACT NOW - Before it is too Late! **Jayne Robbie**
14.15-14.30 Lessons Learnt from NHS Resolution **Michelle Stafford**
14.30-14.45 The Role of the Vascular Skilled Podiatrist **Martin Fox**
14.45-15.05 MDFT Review and Transformation **Richard Paisey and Angie Abbott**
15.05-15.15 Discussion

PARALLEL SESSION 6 VASCULAR & PLASTIC SURGERY:
SOFT TISSUE & VASCULAR RECONSTRUCTION OF DIABETIC FOOT
(Gallery Room) **Chairs: James Chan and Asmat Din**

13.30-14.00 Proceed to St. Pancras Room for Industry sponsored symposium - **CONVATEC**
14.00-14.20 The Role of the Plastic Surgeon in Diabetic Foot Care - the Ganga Hospital Experience **Madhu Periasamy**
14.20-14.40 Soft Tissue Recon for Other Diabetic Foot Problems **Rebecca Shirley & James Chan**
14.40-14.55 Deep Venous Arterialisation - The Intervention **Hany Zayed**
14.55-15.05 Perioperative Care of Deep Venous Arterialisation **Prashanth Vas**
15.05-15.15 Discussion

SESSION 9: THE FINAL REFLECTIONS ON CHARCOT FOOT
(Hall One) **Chairs: Tom Hester and Fermin Martinez de Jesus**

15.05-15.15 Charcot Foot Birth to Cradle - Managing the Milestones **Erika Vainieri**
15.15-15.25 The Conundrum on the Subtalar- to be Included or Not? **Venu Kavarthapu**
15.25-15.40 **KEYNOTE:** Lessons Learned from a Lifetime of Charcot Reconstructions **Dane Wukich**
15.40-16.00 Discussion and Rapid-Fire Case Discussions **Alex Wee and Ngwe Phyo**

PARALLEL SESSION 7:
CHARING CROSS (CX) AT KING'S
(Gallery Room) **Chair: Mike Edmonds**

15.15-15.25 The MARS Project- How we halved lower limb amputations and increased capacity over 6 years within existing resource **Naseer Ahmad**
15.25-15.35 Incidence of Peripheral Vascular Disease & Need for Revascularization in Charcot Foot **Hani Slim**
15.35-15.45 Advances in Multidisciplinary Limb Salvage **Mike Edmonds**
15.45-16.00 Discussion

Wednesday 15th October

PARALLEL SESSION 8: MAINTAINING REMISSION
(St. Pancras Room)

Chairs: Maureen Bates and Chris Manu

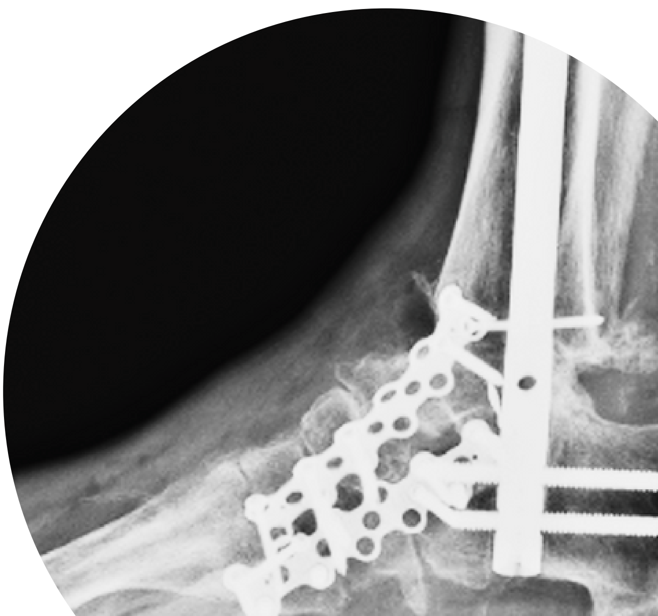
15.15-15.25 An Ideal Footwear Following Diabetic Foot Reconstruction **Chris Pankhurst**
15.25-15.35 Modern Advances and Technologies in Diabetes Control **Omar Mustafa**
15.35-15.50 Technology in Primary Prevention of Diabetic Foot **David Armstrong**
15.50-16.00 Discussion

16:00 TEA | INDUSTRY EXHIBITION | POSTERS (Gallery level)

SESSION 10: CROSSFIRE IN DIABETIC FOOT SURGERY
(Hall One)

Chairs: Mike Edmonds and Venu Kavarthapu

16.20-16.30 How to Avoid Secondary Deformity Following a Vascular Procedure **David Russell**
16.30-16.40 Prevention of Vascular Complication During Deformity Corrections **Venu Kavarthapu**
16.40-16.50 The Way Forward: Collaboration in the MDFT **Mike Edmonds**
16.50-17.00 Discussion
17.00-17.10 Take home message, prizes, closure



16:20 - 16:26

SIX-MONTH OUTCOMES AFTER DIABETIC FOOT ATTACK

Federico Rolando Bonanni[1,2], Martina Salvi[1,2], Ermanno Bellizzi[1,2], Aurora Buccolini[1], Luigi Uccioli[1,3], Valeria Ruotolo[2], Alfonso Bellia[1,2], Davide Lauro[1,2], Marco Meloni[1,2]
[1]Department of Systems Medicine, University of Rome Tor Vergata, Rome, Italy. [2]Division of Endocrinology and Diabetology, Department of Medical Sciences, University Hospital Fondazione Policlinico Tor Vergata, Rome, Italy. [3]Division of Endocrinology and Diabetes, Department of Systems Medicine, CTO Andrea Alesini Hospital, Rome, Italy

The study evaluated mid-term outcomes of patients admitted for diabetic foot attack (DFA).
Retrospective observational study including patients admitted for diabetic foot ulcers (DFUs). Based on hospital admission (emergency or elective), patients were divided into two groups: DFA and chronic diabetic foot (CDF). DFA was considered in case of ischemia (acute or quick impairment of chronic condition), moderate/severe infection and complicated Charcot foot with severe deformities and/or infected ulceration. Quick antibiotic and surgical approaches were adopted for infected DFA, and early revascularization for ischemic DFA.

Once discharged, patients were followed as outpatients and the following six-month outcomes were evaluated: healing, major amputation, mortality, readmission, major adverse limb and cardiovascular events (MALCE) including nonfatal myocardial infarction, nonfatal stroke, cardiovascular death, and critical limb ischemia requiring revascularization.

Overall, 141 patients were included. The mean age was 70±12 years, most patients were male (76.6%), had type 2 diabetes (93.6%) with a mean duration of 22±13 years; 57.4% patients presented DFA while 42.6% CDF. The DFA group reported greater rate of foot infection (81.5vs50.0%,p=0.0002), higher HbA1c values (67±22vs56±14 mmol/mol,p=0.0008) and more cases of first assessment for DFUs (59.3vs13.3%,p<0.0001) when compared to the CDF group.

Six-months outcomes for DFA and CDF were: healing (65.4vs60.0%,p=0.3), major amputation (4.9vs1.7%,p=0.2), mortality (8.6vs11.7%,p=0.5), readmission (27.2vs26.7%,p=0.8); MALCE (9.9vs23.3%,p=0.1).
Patients admitted for DFA did not show different post-hospitalization outcomes when compared to CDF patients. Prompt and multidisciplinary management seems to ensure favourable mid-term outcomes also in case of DFA.

16:26 - 16:32

COST ANALYSIS OF FLAP RECONSTRUCTION FOR PATIENTS WITH DIABETIC FOOT ULCERS

Bryant Chong, Jayne Edmonds, Rebecca Shirley, James Chan
Stoke Mandeville Hospital, Aylesbury, United Kingdom

Diabetic foot disease costs NHS England up to £1 billion annually. Flap reconstruction can improve limb salvage, quality of life, and survival in patients with diabetic foot ulcers(DFUs), but its cost-effectiveness remains unclear. This study evaluates the economic impact of flap reconstruction for DFU in a single UK centre.

Retrospective cohort cost analysis was conducted for patients undergoing flap reconstruction for DFU between 2019–2024. Data on hospital admissions, surgery, outpatient care, podiatry, and community services were collected one year pre-op to two years post-op. Costs were calculated using institutional and NHS tariff data.

Fourteen reconstructions (9 free, 5 pedicled) were performed. There were 0 complete and 2 partial flap failures (no further reconstruction required). Median length of stay was 18 days (range 2–58). All limbs were salvaged at 1 year; by year 2, there was 1 amputation and 0 deaths. Median cost of the reconstruction episode was £25,250. Average patient costs were £21,519 in the year before surgery, falling to £4,487 in year 1 and £954 in year 2. Median hospital admission days were: 18 in the year before reconstruction, and 1 and 0 in year 1 and year 2 after reconstruction, respectively. NHS tariff is estimated at £11,000.

Flap reconstruction appears cost-effective in appropriately selected DFU patients, with costs recovered within a year and significantly reducing days of hospital admissions. Wider adoption may help mitigate growing economic burden of diabetic foot disease in the NHS.

16:32 - 16:38

PEAK PLANTAR PRESSURE AS A PROGNOSTIC MARKER IN CHARCOT NEURO-OSTEOARTHROPATHY

Victoria Milbourn[1], Sicco Bus[1], Nina Petrova[2], Jaap van Netten[1]
[1]Amsterdam UMC, Amsterdam Movement Sciences, Amsterdam, Netherlands.
[2]King's College Hospital NHS Foundation Trust, London, United Kingdom

The influence of biomechanical factors on Charcot neuro-osteoarthropathy (CNO) progression remains unclear. This study aimed to examine whether barefoot peak plantar pressures (PPP) at diagnosis are correlated with time to remission, and to identify PPP thresholds as prognostic indicators for slow remission.

A retrospective cohort analysis was conducted in 17 people with active CNO who underwent barefoot PPP assessment using the Emed-X pressure platform at diagnosis. Baseline demographic, clinical, and biochemical characteristics were collected, along with anatomical classification of bony involvement and time to remission. Correlations between PPP and time to remission were assessed using Spearman's rho. Receiver operating characteristic (ROC) curve analysis was performed to identify PPP thresholds predictive of slow remission, defined as >120 days.

Mean participant age was 58±13 years; 65% were female and 71% had type 2 diabetes. A moderate correlation was observed between lateral midfoot PPP and time to remission ($\rho=0.458$, $p=0.064$). No significant correlations were found for medial midfoot, hindfoot, or total foot PPP (ρ ranging from –0.001 to 0.315). A lateral midfoot PPP threshold of >141 kPa demonstrated moderate prognostic performance for predicting slow remission.

Higher lateral mid-foot PPP was moderately correlated with prolonged time to remission in CNO. Thresholds derived from this region showed moderate predictive performance, supporting their potential prognostic value in identifying slow remission.

16:38 - 16:44

ORTHOPLASTIC TECHNIQUES FOR DIABETIC ULCER LIMB SALVAGE SURGERY - THE MAJOR TRAUMA APPROACH

Iris H Y Kwok, Arvind Mohan, Kshemendra Senarath-Yapa, Naveethan Sivanadarajah
Imperial College Healthcare NHS Trust, London, United Kingdom

Most diabetic MDT services are led by diabetologists, vascular surgeons, orthopaedic surgeons and podiatrists. While established plastic surgery techniques have long been used in the major trauma setting, the same techniques in diabetic patients have yet to become a mainstream option in diabetic limb salvage. We describe our tertiary centre experience of an early proactive joint orthoplastics approach, utilising a similar model to major trauma care.

We retrospectively reviewed our tertiary centre experience of a series of 16 joint orthoplastic diabetic neuropathic ulcer cases between 2020-25 in whom all other treatment modalities had failed and amputation was a viable option.

The mean age was 59 years old. We achieved limb salvage in 14 out of 16 patients (88%). Mean follow up time was 32 months. A bespoke orthoplastic major trauma approach to diabetic foot care was employed, using a range of techniques including free flaps, microvascular techniques, local flaps, single-stage aggressive bony resection with direct closure, skin and synthetic dermal grafts. Early joint consultant-led planning of surgical treatment was adopted.

A clear soft tissue coverage plan is integral to successful limb salvage. Our bespoke orthoplastic major trauma approach to diabetic ulcer care has been shown in this setting to be a clinically and cost-effective alternative to existing diabetic ulcer management pathways and highlights the critical importance of the previously overlooked early involvement of plastic surgeons within the surgical planning of this complex patient group.

16:44 - 16:50
ISCHAEMIA IN CHARCOT FOOT ORTHOPAEDIC SURGERY
James Barnett, Hani Slim, Venu Kavarthapu
King's College Hospital NHS Foundation Trust, London, United Kingdom

Charcot arthropathy frequently presents with deformity and ulceration with a significant subset developing peripheral vascular disease. These patients tend to be co-morbid and at greater risk of complications. In cases suitable for orthopaedic surgery, vascular assessment is required and where necessary intervention to ensure a successful outcome. The aim of this study was to assess the prevalence of ischaemia in cases of Charcot foot that required orthopaedic surgery.

Patients with a diagnosis of Charcot arthropathy were retrospectively identified from radiology reports over 2-years. All cases with a diagnosis of Charcot were included and underwent ultrasound doppler assessment. Minimum follow up was 8 years. Demographic data, vascular imaging findings and interventions were collected.

170 cases were included, mean age 62 years (range: 26–92). Doppler studies revealed stenosis in 49.4% (84/170) of patients. Of those, 53.6% (45/84) underwent angioplasty and 14 had subsequent bypass surgery. Non-vascular surgical intervention was performed in 91 cases (53.5%), comprising 51 minor amputations, 17 Charcot reconstructions, 17 exostectomies, and 8 below-knee amputations. Within the surgical group, 60% (55/93) had evidence of stenosis, and 27% (25/93) underwent angioplasty pre-operatively. All cases requiring below-knee amputations had vascular stenosis, compared with 35% (6/17) of those that underwent Charcot reconstruction.

This study demonstrates a high prevalence of ischaemia and the need for combined vascular and orthopaedic assessment in Charcot foot cases. Routine vascular assessment and timely revascularisation are essential parts of multidisciplinary care to maximise the potential for limb salvage.

16:50 - 16:56
A NOVEL COMBINED APPROACH TO DEFORMED ISCHEMIC CHARCOT FOOT AND ANKLE: A CASE REPORT ON RECONSTRUCTION WITH TRANSVERSE TIBIAL BONE TRANSPORT
Patricia Lee, Chris Manu, Erika Vainieri, Thomas Hester, Venu Kavarthapu
Mike Edmonds Foot Unit, King’s College Hospital NHS Foundation Trust, London

Charcot neuroarthropathy is a progressive and destructive disease that may lead to severe foot deformity and ulceration. Reconstructive surgery is often necessary to preserve limb function and prevent amputation. Transverse Tibia bone Transport (TTT) is a surgical technique based on Ilizarov’s law of tension-stress. It applies mechanical distraction to bone and soft tissue to stimulate angiogenesis and microcirculation. While TTT has demonstrated success in managing diabetic neuropathic and ischaemic ulcers, its application alongside Charcot reconstruction surgery has not been previously reported.

A 75-year-old male with Type 2 diabetes (HbA1c 62mmol/mol) presented with Charcot arthropathy of the foot and ankle with a chronic plantar ulcer. Duplex ultrasound showed patent dorsalis pedis artery and occluded posterior plantar artery which were considered non-reconstructable by the vascular members of the diabetic foot multidisciplinary team. The patient underwent a minimally invasive midfoot and hindfoot Charcot reconstruction with a simultaneous application of a tibial cortex window transverse transfer mini-external fixator. Perioperative antimicrobial therapy was administered. Postoperatively, a standardised protocol of bone distraction was adopted and the bone healing response was monitored via serial radiographs. Regular post operative wound care and casting were maintained throughout. The external device was removed at week 8, and the patient remained non-weight bearing in a total contact cast for 12 weeks before transitioning to partial weight bearing.

Bone healing was satisfactory with no metal work complications or signs of infection throughout the treatment period. Complete healing of the plantar ulcer was observed at week 8. At nine months postoperatively, the patient was fully weight bearing and began transitioning to custom footwear and orthotics. The overall outcome was positive.

This case demonstrates the potential for integrating TTT with Charcot reconstruction surgery in the management of complex foot deformities complicated by uncorrectable ischemia, when combined with diligent monitoring and wound management within a multidisciplinary team.

16:56 - 17:02

STRUCTURED MULTIDISCIPLINARY APPROACH TO CHARCOTMIDFOOT RECONSTRUCTION: TWO- YEAR OUTCOMES FROM A TERTIARY CARE DIABETIC FOOT UNIT IN INDIA.

Prasanna Garapati, Srinivas Seshabhattaru, Raja Sekhar Vuyyuru, Venu Kavarthapu
Diabetic Foot Centre of Excellence, Apollo Jubilee Hills Hospital, Hyderabad, India

Charcot neuroarthropathy (CN) remains a formidable limb-threatening complication in patients with diabetes, particularly in resource-limited, high-prevalence settings. Amputation rates for diabetic Charcot foot and ankle deformities are high in India and other Asian countries due to the lack of structured, multidisciplinary team (MDT)-delivered Charcot deformity corrections.
We present the medium-term outcomes of reconstruction of CN foot and ankle deformities performed at a dedicated, structured, multidisciplinary diabetic foot centre in South India.

Between January2022 and December2023, 32 patients with Eichenholtz stage II/III Charcot deformities of the foot/ankle underwent reconstructive procedures utilizing internal fixation techniques, performed by the senior author. This effort was coordinated by a unified multidisciplinary team comprising endocrinologists, orthopaedic and podiatric surgeons, vascular specialists, infectious disease consultants, and wound care professionals. The cohort consisted of 19 males and 13 females with a mean age of 57.7 years. All had peripheral neuropathy from diabetes, with CN contributing to the deformity. Four patients had ulcers at presentation, of which three were actively infected. Two-stage reconstruction was performed in the four actively infected feet, and one-stage reconstruction was performed in 28 feet. There were 26 isolated midfoot, 5 isolated hindfoot, and 1 combined hindfoot and midfoot reconstructions. Post-operative management included antibiotic administration and offloading in a total contact cast for a minimum of three months followed by custom shoes and insoles.

The primary endpoints evaluated included foot stability, ulcer resolution, and avoidance of major amputation. Secondary endpoints included re-ulceration, complication rates, and functional ambulation. At the final review, with a mean follow-up 24-months, 25 patients (90.6%) maintained a stable, plantigrade, and ulcer-free foot with restored ambulatory capacity. All ulcers healed within three months, and 20 patients achieved full bone healing. There were no post-operative wound infections or metalwork failures. Fourteen patients were mobilizing with full weight-bearing in custom-moulded insole shoes, three in a CROW walker, and four were partially weight-bearing in a total contact cast. Nine patients remained non-weight-bearing in a total contact cast. One mortality occurred due to cardiac causes. Limb salvage was achieved in all but two patients. One patient developed melanoma in the operated limb requiring below-knee amputation, and two developed CN of the ankle joint post-midfoot reconstructions, with one requiring a below-knee amputation.

Our findings affirm that a protocol-driven, multidisciplinary approach enables successful functional limb salvage for CN foot and ankle deformities with durable functional outcomes, even in complex presentations. This model, designed for a high-risk diabetic population, offers valuable insights for centres worldwide seeking to implement a comprehensive, team-based approach to CN foot and ankle deformities.

17:02 - 17:08

TRANSFORMATION OF THE TRADITIONAL MULTIDISCIPLINARY DIABETIC FOOT CLINIC INTO A FOOT UNIT: FOLLOW-ON RESULTS OF A SERVICE EVALUATION

Meghana Kavarthapu, Claire Sommerville, Maureen Bates, Venu Kavarthapu, Hani Slim, Prashanth Vas,
Michael Edmonds, Chris Manu
Mike Edmonds Foot Unit, King's College Hospital NHS Foundation Trust, London

In 1981 the concept of more than one specialist reviewing a patient presenting with a diabetes related foot problem within a joint clinic was first established. However, with the progression of patient's complexity, the structure of the service needed has also changed. The aim was to conduct a service evaluation to delineate the clinical demand and nature of clinic visits, within a modern multidisciplinary foot service.

This was a retrospective review of all attended clinic visits over a six-week period. Booked appointments were extracted from the clinic database and individual electronic clinical notes were reviewed for each clinic visit. A database was then setup for theses with analysis of patient demographics, clinic activities performed during clinic visit and outcomes.

There were a total of 1142 attended appointments by 586 individual patients. Male 67%, mean age 62±14yrs, 69% with type 2 diabetes, 7% did not have diabetes. Up to 23% of patients had 3 or more appointments during the six-week period. Of the 1142 appointments, 12% of the appointments were emergency walk-ins, thus by patients turning up with a pre-booked appointment, of which 16% were for new patient to the service. But 1009 of the appointments were pre-booked, of which 6% were new-patient appointments and 94% were follow-up appointments. 15% of appointments were seen in a joint clinic with the orthopaedic surgeons and another 15% with the vascular surgeons. At least 41% of the patient appointments needed an input from the diabetologist. All patients were seen by a podiatrist but 20% of appointments needed an input from diabetic foot specialist nurse, assisting in administration of antibiotics and performing blood tests. For same day clinic review, 19% of appointments had a blood test done for infection, as did 13% having foot x-rays and 5% had an arterial duplex scan. At least 10% were seen while on renal haemodialysis machine. For 32% of appointments, patients were on antibiotics and overall, 12% of the appointments were on parenteral antibiotics via intravenous or intramuscular route administered by a nurse within the clinic. Only 7 appointments resulted into an admission into hospital.

This service review demonstrates the complexity of the calibre of appointments needed by this group of patients. Evidently the clinic now functions more as a day unit with same-day and one-stop multidisciplinary management of patients with diabetic foot complications rather than the previously perceived concept of a routine clinic appointment.

17:08 - 17:14

NATIONAL SURVEY OF PLASTIC SURGERY INVOLVEMENT IN DIABETIC FOOT CARE IN ENGLAND

Rachel Enright[1], Isabella Stevens Harris[2], James Chan[2]
[1]St Vincents Hospital, Dublin, Ireland. [2]Buckinghamshire Healthcare NHS Trust, Aylesbury, United Kingdom

To evaluate the current landscape of Plastic Surgery involvement in diabetic foot care across NHS England.

A cross-sectional survey was distributed via email to all plastic surgery units in NHS England. The questionnaire collected information on Plastic Surgery participation in diabetic foot multidisciplinary teams (MDFTs), annual consultation volumes, referral sources, and the indications for these referrals. Units without a dedicated diabetic foot MDT e.g. paediatric or cancer specialist hospitals were excluded. A total of 48 eligible units were identified. For the purpose of this study, "diabetic foot" was defined as cases involving diabetic foot ulcers and acute infections ("foot attacks"). Cases related to trauma or elective surgery in diabetic patients were excluded.

Responses were received from 79% of eligible units. Among these, 71% reported no Plastic Surgery representation in their MDFT. However, 29% reported over 20 annual Plastic Surgery consultations for diabetic foot-related issues. The most frequent reason for referral (71%) was soft tissue reconstruction following foot ulceration. Notably, 59% of units reported encountering cases involving failed reconstructions initially performed by non-plastic surgeons at least once a year.

Plastic Surgeons play a vital yet under-recognised role in diabetic foot management. While the majority of care is currently led by other specialities, there is a demonstrable need for specialist input in complex soft tissue reconstruction. Improved recognition, formalised involvement in MDFTs, and dedicated training pathways are essential to integrate Plastic Surgery into diabetic foot care.

08:30 - 08:36

INTERDISCIPLINARY HIGH-RISK FOOT SERVICE IN REMOTE WESTERN AUSTRALIA: LESSONS LEARNT

Sarah Tomlinson[1], Donna Larsen[2], Johanna Van Rooyen[2], Cara Westphal[2], Jessica Harrison[2], Olufemi Oshin[2]
[1]Broome Regional Hospital, Broome, Australia. [2]Royal Perth Hospital, Perth, Australia

Diabetes-related foot disease (DFD) is the most important cause of non-traumatic lower-extremity amputations (LEA) globally. In rural/remote communities of Western Australia, inequitable access to specialist services has entrenched disparity in outcomes, particularly the Aboriginal and Torres Strait Islander population who remain exposed to unacceptably high LEA risk.

A podiatry-led inter-disciplinary high risk foot service (IHRFS) with remote specialist support was established in 2021. Qualitative (semi-structured interviews of patient and staff experience) and quantitative (DFD patterns of presentation and outcome data) for the service was undertaken to inform the replication of sustainable models of care for rural/remote IHRFS.

IHRFS activity has increased in the study period (likely a positive surrogate marker of community engagement); however, LEA risk remains stubbornly high. The regional tropical climate has implications for wound management and may be an important epidemiological factor, with DFD presentations peaking after the wet season. Penetrating and thermal injuries also seem to be more common DFD aetiologies compared with metropolitan patients. Qualitatively it is clear that distrust of "Western medicine" runs deep and is frequently associated with a strong belief it is directly responsible for limb loss. A strong focus on cultivating interpersonal relationships has been critical in effectively promoting early presentation.

Improving rural/remote DFD outcomes is a slow process; socioeconomic status/funding remain significant barriers to success. Investing in individuals able to establish strong interpersonal relationships presents significant opportunity and risk when commissioning IHRFS.

08:36 - 08:42

VESSELS AT RISK: SECONDARY PREVENTION FOR VASCULAR SURGERY PATIENTS

Mefin Jose[1,2], Anisha Joseph[1]
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Patients with diabetic foot disease are at high risk of cardiovascular events and limb loss, largely due to underlying atherosclerosis and pro-thrombotic states. Guideline-recommended secondary prevention using anti-platelet agents and statins is vital in reducing morbidity and mortality in this population. However, evidence consistently shows gaps in the prescription of these therapies.

A two-cycle closed-loop audit was conducted to assess the prescribing of anti-platelet and statin medications at admission and discharge for patients admitted with diabetic foot complications between April 2023 and April 2024. Following the initial audit, interventions were introduced to promote adherence to secondary prevention guidelines, including targeted education and improvements to the documentation process. A prospective re-audit was then undertaken from May to September 2024 to evaluate the impact.

In the pre-intervention cohort of 289 patients, 63.2% were already on an anti-platelet or anti-coagulant and statin on admission, compared to 49% of 124 patients in the post-intervention group. Among those not on such therapies at admission, 36% were started on anti-platelets and 40% on statins by discharge. Post-intervention, these rates increased to 65% and 43.6%, respectively.

Despite improvements, 26% of patients in the pre-intervention cohort and 13% post-intervention were discharged without any secondary prevention therapy. This highlights ongoing gaps in care and the need for continued efforts to improve prescribing practices for this high-risk group.

08:42 - 08:48

ASSESSING KNOWLEDGE, ATTITUDES, AND PRACTICES OF HEALTH CARE WORKERS ON DIABETIC FOOT ULCERS IN KENYA

Shilpa Mulki[1,2], Jasmit Shah[3], Rilwan Adan[1,4], Saira Sokwalla[5,6], AbdulMalik Halkano[7], Fabian Collis[1,2], Partha Kar[8]
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Diabetic foot ulcers (DFUs) are a major yet preventable complication of diabetes, often leading to amputations, especially in resource-limited settings. In Kenya, where diabetes is on the rise, foot care remains underprioritized. Healthcare providers are critical to early detection and management, yet limited data exist on their knowledge, attitudes, and practices. This study assessed these factors among Kenyan healthcare workers to identify gaps and guide improvements.

A cross-sectional survey was conducted between January 15, 2024, and January 15, 2025, among healthcare professionals involved in diabetes or wound care across Kenya. A structured questionnaire assessed demographics, knowledge, attitudes, and practices related to DFU care. Ethical approval was obtained from Kenyatta University and NACOSTI. Data were collected via Google Forms and analysed using SPSS Version 20.0.

A total of 399 healthcare providers from 40 counties participated, with general nurses (43.6%) being the largest group. While 61.4% reported using a multidisciplinary approach, access to podiatrists (7.0%) and vascular surgeons (15.5%) was limited. Confidence in DFU management was lacking among 21.3%. Most used normal saline (60.2%) and povidone iodine (59.4%) for wound care, but 65.2% lacked access to Ankle-Brachial Pressure Index (ABPI) assessments. Though 96.5% supported national DFU guidelines, only 43.1% had a referral system.

Significant gaps in knowledge, confidence, and resources exist. Strengthening training, specialist access, and national guidelines is critical to improving DFU outcomes in Kenya.

08:48 - 08:54

SCALABLE FABRICATION OF PLASMONICALLY-ACTIVE NANONEEDLES FOR ANTIMICROBIAL SURFACES

Ryan Bower[1], David Owen[2], Bruno Rente[1], Rupert Oulton[1], Arutiun Ehiasarian[2], **Thomas Smith**[2], Peter Petrov[1]
[1]Imperial College London, London, United Kingdom. [2]Sheffield Hallam University, Sheffield, United Kingdom

The global rise of antimicrobial resistance (AMR) poses a critical public health and economic threat, with bacterial infections becoming increasingly difficult to treat. Antimicrobial surfaces (AMSs) offer a promising antibiotic-independent alternative. Wide-ranging applications include minimising transmission of infections via common-touch surfaces in the indoor built environment (including hospitals), antimicrobial wound dressings to prevent or treat infections, and antimicrobial surfaces to combat infection of indwelling medical devices and prostheses.

Naturally bactericidal surfaces like cicada and dragonfly wings possess nanoneedle structures that disrupt bacterial cells and inhibit biofilm formation. Titanium nitride (TiN) is a compelling material for such applications due to its mechanical robustness, chemical stability, biocompatibility, and plasmonic properties, which may enhance bactericidal effects under light activation via production of reactive oxygen species.

The ROMANS project (Robust Manufacturable Antimicrobial Surfaces) has employed High Power Impulse Magnetron Sputtering to produce high-density plasmonically active TiN films and fabricated TiN nanoneedle arrays using electron beam lithography (EBL), which are predicted to have both mechanical and plasmonically-derived antimicrobial properties. Detailed physical characterisation has confirmed the structure and plasmonic activity of these surfaces. Tests with the key pathogenic bacterium Staphylococcus aureus show >90% killing under ultraviolet illumination, compared with an unfunctionalized glass surface. Work to develop the fabrication process for large-scale production of the coated surfaces will be presented, together with their antimicrobial characterisation and mechanical wear resistance, highlighting the potential of such materials for real-world deployment in the healthcare sector and public infrastructure.

08:54 - 09:00

HEEL DIABETIC FOOT OSTEOMYELITIS: A CURRENT CHALLENGE IN THE CLINICAL PRACTICE

Martina Salvi[1,2], Marco Meloni[1,2], Federico Rolando Bonanni[1,2], Ermanno Bellizzi[1,2], Luigi Uccioli[3], Valeria Ruotolo[1,2], Alfonso Bellia[1,2], Davide Lauro[1,2]
[1]Department of Systems Medicine, University of Rome Tor Vergata, rome, Italy. [2]Division of Endocrinology and Diabetology, Department of Medical Sciences, University Hospital Fondazione Policlinico Tor Vergata, rome, Italy. [3]SE/CTO Hospitals ASL Roma2, University of Rome Tor Vergata, rome, Italy

To evaluate the long-term outcomes of heel diabetic foot osteomyelitis (DFO) managed in a specialised diabetic foot service

The retrospective observational study included patients with diabetic foot ulcers complicated by DFO, treated from 2019 to 2022. Management followed a local protocol aligned with international guidelines, combining antibiotic therapy and surgery as needed. Patients were divided based on infection site: heel DFO versus forefoot/midfoot DFO. Outcomes evaluated after one year included healing rate, healing time, and the rate of major amputation.

Overall, 114 patients were included. The mean age was 67.9 ± 12, most of them were male (72.8%) and had type 2 diabetes (91.2%); 84 (73.6%) of patients reported forefoot/midfoot DFO, while 30 (26.3%) reported heel DFO. Patients with heel DFO showed greater rate of soft tissue infection (80 vs 68.7%, p= 0.04), ulcer size >5cm (93.3 vs 34.3%, p= <0.0001), gangrene (63.3 vs 22.9%, p= <0.0001), higher C-reactive protein values (67.6 ± 25 vs 24 ± 16 mg/dl, p= 0.0002) and concomitant peripheral ischemia (83.3 vs 52.4%, p= 0.0002).
Outcomes for heel DFO and forefoot/midfoot DFO were: wound healing (66.7 vs 97%, p= <0.0001), healing time (14 ±6 vs 6.8 ±5 weeks, p=<0.0001), and major amputation (10% vs 0%, p= 0.0002) respectively.

Heel DFO resulted associated with a higher risk of major amputation, reduced chance of healing, and longer healing time.

09:00 - 09:06

LARVAL DEBRIDEMENT THERAPY IN INDIVIDUALS WITH DIABETIC FOOT ULCERS INTOLERANT TO STANDARD SHARP DEBRIDEMENT: A 12-WEEK COMPARATIVE OUTCOMES EVALUATION

Siti Khamsiah Binti Abd Shukor[1,2], Caoimhe-Joyce Hearne[1], Alpa Lakhani[1], Prashanth Vas[1], Tejal Patel[1],
Amina Ceesay-Jaiteh[1], Vaishali Desai[1], Disha Bhavsar[1], Lim Shipin[1], Tanya Chapman[1], Hany Zayed[1], Michael Robinson[1], Stephen Thomas[1]
[1]Guy's and St Thomas' NHS Foundation Trust, London, United Kingdom. [2]Klinik Kesihatan Batu Arang, Selangor, Malaysia

We aimed to evaluate the clinical impact of larval debridement therapy (LDT) in individuals with peripheral arterial disease (PAD) and diabetic foot ulceration (DFU), unresponsive or intolerant regular sharp debridement.

A retrospective observational evaluation of individuals (n=49) treated with LDT between 2023 and 2025. All had either failed ≥3 sharp debridement or limited by pain. The standard care group (SC) consisted of 16 individuals with PAD, who continued to receive sharp debridement. Revascularization, offloading and infection control routines were aligned with local policy for both groups.

There were no significant differences between the groups for age, gender, or prevalence of PAD. Importantly, the LDT cohort began with significantly more compromised wound beds: 89.8% of cases had DFU-area slough coverage>50% at baseline compared to 0% in the SC group, and only 4.1% demonstrated DFU-granulation coverage >50% at baseline versus 75% in the SC group. By 12 weeks, complete wound healing had occurred in 28.6% of individuals in the LDT group and 31.2% in the SC group (p = 0.82).

In our series, the largest reported in the UK, deployment of LDT demonstrated robust DFU-healing metrics and comparable 12-week healing outcomes to standard care despite significantly worse baseline wound status. These findings support LDT as an effective debridement method in the contemporary DFU care of individuals who cannot tolerate regular sharp debridement.

09:06 - 09:12

YOU WON'T BELIEVE YOUR EYES. VIDEO PRESENTATION ANTERIOR TIBIAL TO PLANTAR ARTERY VEIN BYPASS

Hani Slim, Yasmeen Gouda, Yanxue Li.
King's College Hospital NHS Foundation Trust, London

Vein graft Open bypass revascularization remains an essential part in the management of patients presenting with limb ischemia or patients requiring aneurysmal exclusion bypasses. The challenges in traditional major open bypass revascularisation, particularly in the older population remain the high perioperative complications including large wounds, extensive dissections, poor mobility, major blood loss, infection, post-operative complications.

To Introducing the Minimal Invasive Novel Open Revascularization (MINOR) approach. Utilizing minimal incisions and dissections for bypass to minimize the peri and post-operative complications. MINOR has 3 main criteria's

- Shorts Vein bypass revascularization
- Endoscopic vein harvesting (EVH)
- Least amount of tissue damage

Leading to faster recover with the minimal perioperative morbidities.

A video presentation of a MINOR approach Anterior tibial to Plantar artery vein bypass.

The MINOR approach technique in open limb bypasses is an efficient and safe procedure with no major adverse effects and excellent, outcome.

09:12 - 09:14
WHOLE-PERSON STRATEGIES FOR DIABETIC FOOT ULCERS: FROM BIOMECHANICS TO EPIGENETICS
Jengyu Lai
Rochester, Rochester, United States

Diabetic foot ulcers (DFUs) are complex clinical challenges resulting from the interplay of neuropathy, biomechanical stress, impaired circulation, and systemic metabolic dysfunction. Effective and lasting management demands a whole-person approach that addresses both the wound and the broader determinants of healing, especially diabetes management.

This presentation outlines an integrative care model that combines biomechanical assessment, evidence-based local wound care, and lifestyle medicine interventions, fully aligned with contemporary standards of care.

Biomechanical evaluation identifies gait abnormalities, deformities, and pressure points, guiding individualized offloading strategies, including the use of braces and therapeutic footwear. Local wound care incorporates sharp debridement, appropriate dressing selection, and infection control, with adjunctive technologies such as digital imaging and tissue oximetry to assess perfusion and monitor healing trajectories.

At the core of this model are the pillars of lifestyle medicine: 1) whole-food, plant-predominant nutrition while avoiding tobacco and harmful substances; 2) regular physical activity; 3) restorative sleep; 4) effective stress management; 5) strong social connection, and 6) passion. These interventions not only enhance metabolic control and circulation but also influence gene expression through epigenetic mechanisms—promoting anti-inflammatory pathways, immune regulation, and tissue regeneration.

This comprehensive, root-cause-oriented framework empowers patients, improves healing outcomes, reduces recurrence, and preserves limb function. It reflects a more human-centered and science-driven paradigm—one that sees beyond the wound and treats the person.

09:14 - 09:16
SGLT2I'S IN ACUTE DIABETIC FOOT
Poorvi Sharma
St. George's Hospital, London, United Kingdom

Aims :
To review the variation in practice in SGLT2 inhibitor use in patients with diabetic foot infections and associated outcomes.

Objectives:
1. To review the prevalence of SGLT2 inhibitor use in people with diabetes presenting to the SGH diabetic foot clinic.
2. To review the discontinuation rates of SGLT2 inhibitor use in patients presenting with diabetic foot infection.
3. To review the complications and outcomes of diabetic foot ulcer in these patients

Conclusion:
The St George's Diabetic Foot Clinic treats a high volume of new foot presentations and diabetic foot infections. Despite increasing indications of SGLT2 inhibitors in diabetes, kidney and cardiovascular disease, the prevalence of SGLT2 inhibitors use in our studied cohort was relatively low (18%). There is high variation in discontinuation of SGLT2 inhibitors during the management of acute foot infection. Despite this, the risk of related complications is low; no cases of admission with diabetic ketoacidosis were noted in those who continued SGLT2 inhibitor whilst being treated for acute foot infection. Taking into account audit objectives and aims we conclude that SGLT2 Cessation and recommencing rates aimed at healing majority (54%) of the patients as compared to non cessation of SGLT2 inhibitors aimed at healing 42% of diabetic foot ulcers, considering minor (8%) and major amputation rates (9%).

09:16 - 09:18

IMPACT OF CONTINUATION OF DIABETIC FOOT CLINIC DURING COVID 19 ON AMPUTATION RATES

Meric Kutlay, Anelia Sirkova, Janice Ashton, Victoria Harrison
BHRUT University Hospitals, London, United Kingdom

After the outbreak of the COVID pandemic, many centres had to cut down on face-to-face clinical practice. We understood the impact this would have on patients with diabetic foot pathologies. We decided to continue with our face-to-face diabetic foot clinics and even increased the number of clinics, while following the coronavirus safety guidelines.

We aimed to identify the effect a continuing diabetic foot clinic during the COVID pandemic had on the rates of amputation during the first year of the COVID outbreak. We calculated all lower limb amputations (toe, metatarsal, below knee, above knee) done in our centre between 1 March 2019 to 28 February 2020. We then compared the numbers with the amount between 1 March 2020 to 28 February 2021. We found that amputation numbers decreased by an average of 23% and there was a decrease of numbers in all levels of amputation. Many centres have recorded an increase in amputation cases during the coronavirus epidemic.

Despite having a high number of patients with the coronavirus, our vascular surgery department has in contrast seen a decrease in the amount of amputations during the first year of coronavirus pandemic compared to the previous year. The continuation of our diabetic foot clinics provided patients with a safe clinic with dedicated doctors and allied health professionals.

09:18 - 09:20

3D VIRTUAL SURGICAL PLANNING IN CHARCOT FOOT RECONSTRUCTION: CASE SERIES AND FUTURE DIRECTIONS

Wouter ten Cate[1], Quinten Weusthof[2], Jan Kootstra[1], Kilian Kappert[1,2]
[1]Ziekenhuis Groep Twente, Almelo, Netherlands. [2]University of Twente, Enschede, Netherlands

Charcot neuroarthropathy of the foot poses significant reconstructive challenges due to severe deformity, instability, and high complication rates. Traditional preoperative planning often lacks the precision needed for accurate multiplanar corrections. Three-dimensional (3D) virtual surgical planning enables enhanced visualization and precise preoperative simulation of complex foot deformities.

This case series describes the application of 3D virtual planning in three patients with advanced midfoot Charcot deformity who underwent surgical reconstruction. Patient-specific 3D models were used to simulate osteotomies, alignment corrections, and implant positioning prior to surgery. Postoperative outcomes included radiographic alignment, complication rates, plantar pressure distribution, and early functional recovery.

All three patients achieved satisfactory radiographic correction and a plantigrade foot position. No major complications or reoperations occurred within the 3-month follow-up period. The use of 3D planning contributed to greater intraoperative confidence and enabled accurate correction of complex deformities. Rehabilitation progressed without incident, including protected weightbearing with ankle-foot orthoses from 6 weeks postoperatively.

This case series demonstrates that 3D virtual surgical planning is a valuable adjunct in Charcot foot reconstruction. It enhances surgical precision, can reduce operation time, and could potentially lower complication and revision rates. Continued collaboration with the Department of Biomedical Engineering at the University of Twente aims to optimize patient specific 3D virtual planning and to develop predictive models and patient-specific surgical algorithms further advancing the role of technology in diabetic foot reconstruction.

09:20 - 09:22
INDEPENDENT PRESCRIBING OF ANTIMICROBIAL THERAPY IN PODIATRY
Neala Rezai
Royal Free Hospital, London, United Kingdom

Diabetes mellitus is an extreme and severe health burden associated with multiple co-morbidities. Diabetes foot ulcers and diabetes-related lower limb amputations can lead to increased length of hospitalisation and increased demands in healthcare (Raja et al 2023). Thorough assessment and diagnostics, including sharp debridement and bone biopsy will often be obtained by the podiatrist as the treating clinician (Lipsky et al 2012), and if left untreated can lead to infection, and impediment of healing of foot ulcers (Wang et al 2024).

Antimicrobial resistance is a global threat to public health and the economy (Fitzpatrick et al 2022), and excessive or inappropriate antimicrobial use can have negative effects on patient care, the health system and society. The podiatrist has a crucial role to coordinate care amongst consulting specialists. In some cases, surgery is not possible, and so long-term antimicrobial therapy is the most suitable option (Besal et al 2023). Prescribing practice in podiatry has contributed largely toward broadened scope of podiatry, autonomous practice, and improved outcomes for patients (Fitzpatrick et al 2022). Podiatrist independent prescribers at the Royal Free Hospital in London have historically referred all DFUs with visible bone, probe to bone and / or confirmed osteomyelitis to the infectious diseases / microbiology team.

A clinical audit was carried out by podiatrist independent prescribers within the multidisciplinary foot clinic at the Royal Free Hospital in London to study the antimicrobial prescribing pathway for the treatment of diabetes foot infection, and podiatrist autonomy as independent prescribers.

09:22 - 09:24
MULTIDISCIPLINARY TEAM(MDT)IS CRUCIALFOR CARE IN INSTITUTIONS BUT A MERGED DISCIPLINARY SERVICE (MDS) ISCRUCIAL FOR COMPLEX LIMB SALVAGE IN DIABETIC PATIENTS
Hani Slim, Yasmeen, Gouda, Erica Vianieri, Tim, Parkinson, Mareen Bates, Ragvinder Gambhir, Domenico Valenti, Chris Manu, Venu Kavarthapu, Michael Edmonds
King's College Hospital NHS Foundation Trust, London

The efficacy of the MDT and dedicated diabetic foot clinic has been well established since it was introduced by Professor Michael Edmonds. This has underpinned the St Vincent Declaration when in 1989 it was adopted by the World Health Organization and the International Diabetes Federation with 50% reduction in major amputation in Europe. Since then, the MDT been crucial for diabetic foot care in institutions worldwide. However, there are still a significant percentage of patients undergoing needless major amputation at various institutions and hubs.

The aim of this presentation to Introducing the need to have Merged Disciplinary Service (MDS) among specialized units for complex limb salvage in diabetic patients to provide regional, national and even international support for patients who may end with major amputation

A case series of patients that were offered major amputation at local institutions and hubs but ended with limb salvage revascularization at specialized tertiary unit.

Merged Disciplinary Service (MDS) is crucial for complex limb salvage in diabetic patients.

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WHOLE-PERSON STRATEGIES FOR DIABETIC FOOT ULCERS: FROM BIOMECHANICS TO EPIGENETICS

Jengyu Lai
Rochester, Rochester, United States

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SGLT2I'S IN ACUTE DIABETIC FOOT

Poorvi Sharma
St. George's Hospital, London, United Kingdom

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IMPACT OF CONTINUATION OF DIABETIC FOOT CLINIC DURING COVID 19 ON AMPUTATION RATES

Meric Kutlay, Anelia Sirkova, Janice Ashton, Victoria Harrison
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3D VIRTUAL SURGICAL PLANNING IN CHARCOT FOOT RECONSTRUCTION: CASE SERIES AND FUTURE DIRECTIONS

Wouter ten Cate[1], Quinten Weusthof[2], Jan Kootstra[1], Kilian Kappert[1,2]
[1]Ziekenhuis Groep Twente, Almelo, Netherlands. [2]University of Twente, Enschede, Netherlands

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Donna Rackard Marwa Suwar, **Neala Rezai**,
Royal Free Hospital, London, United Kingdom

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MULTIDISCIPLINARY TEAM (MDT) IS CRUCIALFOR CARE IN INSTITUTIONS BUT A MERGED DISCIPLINARY SERVICE (MDS) ISCRUCIAL FOR COMPLEX LIMB SALVAGE IN DIABETIC PATIENTS

Hani Slim, Yasmeen, Gouda, Erica Vianieri, Tim, Parkinson, Mareen Bates, Ragvinder Gambhir, Domenico Valenti, Chris Manu, Venu Kavarthapu, Michael Edmonds
King's College Hospital NHS Foundation Trust, London

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IMPACT OF A NITRIC OXIDE-GENERATING WOUND DRESSING IN DIABETIC FOOT ULCERS IN PATIENTS RECEIVING ANTIBIOTICS: POST-HOC ANALYSIS

Daniel Metcalf[1], Alan Horner[1], Chris Manu[2], Michael Edmonds[2]
[1]Convatec, Oxford, United Kingdom. [2]King's College Hospital, London, United Kingdom

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THE CHEMICAL AND ANTIMICROBIAL ACTIVITY WITHIN A NOVEL MULTIMODAL NITRIC OXIDE-GENERATING WOUND DRESSING

Nicholas Boote[1], **Daniel Metcalf**[1], Matilda Coleborn[2], Kate Meredith[2], Michael Busby[1], Alan Horner[1]
[1]Convatec, Oxford, United Kingdom. [2]Convatec, Deeside, United Kingdom

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THE EVOLUTION OF WOUND DRESSINGS: PAST, PRESENT, AND FUTURE APPROACHES TO ADDRESS LOCAL BARRIERS TO DIABETIC FOOT ULCER HEALING

Daniel Metcalf[1], Scarlet Milo[2]
[1]Convatec, Oxford, United Kingdom. [2]Convatec, Deeside, United Kingdom

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UTILISING NITRIC OXIDE AS AN ANTIMICROBIAL AND ANTIBIOFILM AGENT WITHIN A WOUND DRESSING IS UNLIKELY TO FACE THE ANTIMICROBIAL RESISTANCE AND TOLERANCE CHALLENGES ASSOCIATED WITH ANTIBIOTICS AND STANDARD ANTIMICROBIAL DRESSINGS

Scarlet Milo[1], **Daniel Metcalf**[2]
[1]Convatec, Deeside, United Kingdom. [2]Convatec, Oxford, United Kingdom

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TRANS-ANKLE AMPUTATION VS TRANS-TIBIAL AMPUTATION FOR EXTENSIVE HEEL ULCERATION AND CALCANEAL OSTEOMYELITIS IN SELECTIVE DIABETIC PATIENTS.

Yasmeen Gouda, Erica Vainieri, Prash Vas, Maureen Bates, Chris Manu, Tim Parkinson, Raghvinder Gambhir, Domenico Valenti, Venu Kavarthapu, Michael Edmonds, **Hani Slim**
King's College Hospital NHS Foundation Trust, London

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A NOVEL ANATOMICAL DESCRIPTION OF THE TERMINAL PERONEAL ARTERY AND THE TERMINAL PERONEAL WINDOW WITH ITS IMPORTANT CLINICAL AND RADIOLOGICAL IMPLICATIONS.

Sebastian Kidar-Smith, Yasmeen Gouda, James Archer, Stephen Gregory, **Hani Slim**
King's College Hospital NHS Foundation Trust, London

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OUTCOME OF OMNIFLOW II GRAFTS IN BYPASS SURGERY IN PATIENTS WITH LOWER LIMB CRITICAL LEG ISCHAEMIA

Jou-Myu Wijnholds, Yasmeen Gouda, Ahmed Elredaisy, Ragvinder Gambhir, Domenico Valenti, Hisham Rashid, **Hani Slim**
King's College Hospital NHS Foundation Trust, London

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TEN YEARS' EXPERIENCE WITH LOWER EXTREMITY BYPASSES ORIGINATING FROM THE TERMINAL PROFUNDA FEMORIS ARTERY: A SINGLE TERTIARY CENTRE OUTCOME

Yasmeen Gouda, Abdullah Thawaba, Ahmed Elredaisy, Domenico Valenti, Hisham Rashid, **Hani Slim**
King's College Hospital NHS Foundation Trust, London

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FREE TISSUE TRANSFER FOR THE MANAGEMENT OF DIABETIC LOWER LIMB ULCERS: A SYSTEMATIC REVIEW AND META-ANALYSIS

Quillan Young Sing1, Tiffanie-Marie Borg2, **Yousif F. Yousif3,** Kai Jian Chin4, Konstantinos Devetzis5,
Sara Sousi6
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