

## Evaluating the Effectiveness of Evidence-Based Nursing Interventions in Preventing and Managing Diabetic Foot Complications: A Systematic Review

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### Review Article

### Abstract:

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Diabetic foot ulcers have emerged as a global health concern in recent decades, leading to severe complications in patients with type 2 diabetes. This study aimed to review and summarize the current evidence-based guidelines for foot care in individuals with type 2 diabetes. Using the PICO framework, a systematic review was conducted, sourcing guidelines from various English databases and the Mahidol University library system. Databases, including PubMed, CINAHL, ScienceDirect, were searched for guidelines published from 2004 to 2014. A total of 33 guidelines were retrieved, with 12 deemed relevant to the study's objectives. These included four international guidelines, seven national guidelines, and one consensus statement. The AGREE II instrument was employed to appraise all selected guidelines. Guideline synthesis revealed five key activities for effective foot care in type 2 diabetes patients: 1) foot assessment, encompassing inspection and examination of the feet; 2) risk assessment and classification into different categories; 3) provision of information to patients and their families regarding foot care, appropriate footwear, and nail care; 4) guidance on blood glucose control; and 5) the referral of at-risk patients to multidisciplinary healthcare teams, particularly in cases of potential serious wound infection and peripheral arterial disease (PAD). This study underscores the importance of utilizing these evidence-based recommendations to develop foot care guidelines tailored to clinical settings in Bangladesh. Strategies for effective guideline implementation should be a priority, with a strong emphasis on distributing these guidelines among healthcare personnel, including nurses, to enhance the quality of care provided to type 2 diabetes patients.

**Key Words:** Diabetic Foot Ulcers, Type 2 Diabetes, Evidence-Based Guidelines, Foot Care, Guideline Implementation.

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## INTRODUCTION

In modern society, diabetes is a pressing global health crisis, with diabetic foot ulcers posing a major challenge [1]. These ulcers not only impact individual patients but also have far-reaching effects on families, communities, and nations [2]. Strikingly, these ulcers often afflict individuals lacking adequate knowledge and skills for diabetes management and proper foot ulcer care [3]. Extensive scientific evidence underscores the importance of foot care education and best practices in foot ulcer management, which can significantly reduce the risk of amputations [4]. Studies consistently show that informed patients and healthcare providers are more likely to engage in effective foot care, leading to a lower incidence of diabetic foot ulcers and related complications [5]. Addressing diabetic foot care comprehensively is crucial in this context.

Proper foot care for individuals with diabetes offers a crucial advantage by reducing the risk of diabetic foot ulcers and subsequent amputations. It involves regular examination, cleanliness, and awareness, ensuring early detection of issues. This preventive approach can enhance overall quality of life, minimize healthcare costs, and alleviate the burden on patients, families, and healthcare systems. Over the past few decades, the prevalence of diabetes has undergone a staggering global upsurge. In the year 2000, an estimated 171 million individuals were living with diabetes, constituting 3% of the world's total population [6]. Disturbingly, projections suggest that by 2030, the prevalence of diabetes is poised to ascend to 366 million, encompassing a substantial 37% of the global population. This dramatic increase in diabetes prevalence has been most pronounced among urban populations and individuals aged 65 and above [7].

The number of individuals affected by diabetes had already surged to 382 million, and projections foresee a further increase to 592 million by 2035, with the majority being adults; International Diabetes Federation (IDF), [8, 9]. Diabetes

now represents a pervasive public health concern, spanning across developed and developing nations, with a significant concentration in low and middle-income countries [1]. In the United Kingdom, approximately 3% of the population is affected by diabetes, while in the United States, the prevalence reaches 9.3% [10], Centers for Disease Control and Prevention (CDC), [11]. Notably, 70% of the 171 million individuals with diabetes are located in developing countries, and by 2030, these nations are projected to host over 80% of the global diabetes population [7].

Bangladesh, a developing country in South East Asia, is not exempt from the escalating diabetes crisis. In 2010, an estimated 5.6 million individuals in Bangladesh were grappling with diabetes, marking a prevalence rate of 6.1%. It is predicted that by 2030, this figure will surge to 10.4 million, positioning Bangladesh among the top 10 countries in the world in terms of diabetic population [12]. Over the past decade, the prevalence of diabetes in rural Bangladesh has seen a substantial increase, soaring from 2.3% to 7.9% [13]. This alarming upward trajectory in the prevalence of type 2 diabetes presents a looming threat of a higher incidence of diabetic foot ulcers in the near future.

Diabetic foot ulcers represent a significant complication for individuals living with diabetes. It is regarded as one of the most devastating and chronic complications, contributing significantly to lower limb amputations, which afflict roughly half of all individuals with diabetes [14]. Most amputations are carried out on patients with type 2 diabetes [15]. Generally, individuals with diabetes face a 10% to 25% risk of developing a foot ulcer during their lifetime. Studies have indicated that the prevalence of diabetic foot ulcers ranges from 4% to 10% among diabetic patients [16]. Notably, older patients exhibit a higher prevalence of foot ulcers, with 10.4% of them suffering from this condition, and 8.5% of diabetic patients experiencing diabetic foot syndrome [17]. A recent study conducted in South Ethiopia revealed a particularly high prevalence rate [18]

Patients with diabetes are significantly more susceptible to amputations than their non-diabetic counterparts [3]. Heel ulcers and amputations are closely correlated, with studies indicating that amputation rates are notably higher among patients with heel ulcers compared to ulcers in other regions of the foot [19]. The book "Diabetes in America" reports that approximately 85% of amputations are conducted on patients with foot ulcers due to diabetes, and the parts of the foot that are commonly amputated are the toe, foot, and ankle, particularly in diabetic patients [20]. Furthermore, the right leg is the limb most frequently affected [4]. A significant proportion of amputations in diabetic patients are performed for non-traumatic reasons [11]. Patients with foot ulcers are admitted to the hospital more frequently and for longer durations compared to those without ulcers [21]. Although many foot ulcers are treatable, a subset of patients takes more than 16 weeks to achieve healing. Tragically, amputations occur at an alarming rate, with more than 2,500 diabetic patients worldwide losing their limbs in a single day [16].

Despite advancements in diabetes care and the introduction of new medications, the rate of amputations continues to rise [22]. Each year, the amputation rate increases by a factor of 1.37 compared to the preceding year [23]. After 12 months of the first amputations, 9% to 20% of patients experience amputations in their second leg, and after five years, the rate increases between 28% and 51%. The mortality rates are significantly higher among patients who have suffered from foot ulcers compared to those without diabetes and those with diabetes but without foot ulcers [24]. Among amputee patients, the mortality rates within the first year range from 13% to 40%, while after five years, they climb to 39%-68% [4,20,3].

The available data in Bangladesh substantiates the rise of foot-related complications among diabetic patients. A similar study in Bangladesh found that the development rate of foot ulcers was 2.8%, with Bangladeshi females disproportionately affected, especially within the 45-65 age group [25]. Additionally, a study revealed high rates of minor amputations among Bangladeshi diabetic patients, with a significant number of artificial limb users' post-amputation hailing from Bangladesh in comparison to Tanzania and India. Post-amputation, the recurrence rates of foot ulcerations, infections, and amputations were recorded at 32%, 11%, and 3%, respectively [26]. Globally, the incidence of diabetes continues to rise, with a concomitant surge in diabetes-related complications, particularly diabetic foot ulcers, which exert a considerable impact on public health [27].

### **Objective:**

#### **General Objective:**

- To enhance the quality of diabetic foot care and reduce the incidence of foot ulcers and related complications in patients with type 2 diabetes.

#### **Specific Objectives:**

- To review and synthesize evidence-based guidelines for diabetic foot care.
- To adapt and customize these guidelines for effective implementation in a clinical setting in Bangladesh.
- To develop strategies for the dissemination and utilization of these guidelines among healthcare providers.

- To assess the impact of guideline implementation on the rate of foot ulcers, amputations, and healthcare costs in patients with type 2 diabetes.
- To promote awareness and education regarding foot care among patients and their families to prevent foot ulcers and complications.

## MATERIALS AND METHODS

### Literature Search Strategy:

A comprehensive literature search was conducted to identify relevant studies and guidelines pertaining to diabetic foot ulcers and evidence-based foot care in type 2 diabetes patients. The following databases were systematically searched: PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Embase, ScienceDirect, and the Cochrane Library. The search was limited to articles and guidelines published between 2004 and 2014. The primary search terms and keywords included "diabetic foot ulcers," "type 2 diabetes," "evidence-based guidelines," "clinical implementation," "foot care," and related terms. Boolean operators "AND" and "OR" were used to combine keywords for each database search.

### Inclusion Criteria:

- Studies, guidelines, and articles related to diabetic foot ulcers and evidence-based foot care in type 2 diabetes patients.
- Publications between 2004 and 2014.
- English language publications.

### Exclusion Criteria:

- Materials not related to diabetic foot ulcers, evidence-based foot care, or clinical implementation in type 2 diabetes patients.
- Publications outside the 2004-2014 timeframe.
- Irrelevant topics, Low-quality or methodologically flawed materials.

### Literature Screening and Data Extraction:

An initial screening of search results was conducted based on titles and abstracts to identify potentially relevant articles and guidelines. The selected articles and guidelines were then subjected to a detailed review. Data were extracted, including study design, methodology, key findings, and recommendations related to foot care in type 2 diabetes patients. Data extraction was performed independently by two researchers, and any discrepancies were resolved through discussion and consensus.

### Literature Quality Assessment:

The quality of the selected guidelines and studies was assessed using the AGREE II (Appraisal of Guidelines for Research and Evaluation II) instrument. This tool evaluates the quality, reliability, and methodological rigor of clinical practice guidelines. Each guideline was assessed by two independent reviewers, and any disagreements were resolved through discussion and consensus.

### Statistical Analyses:

Quantitative data, if available, were subjected to statistical analyses, including descriptive statistics and, where applicable, meta-analysis. For studies reporting clinical outcomes, relevant data such as the incidence of foot ulcers, amputation rates, and healthcare costs were extracted and analyzed using appropriate statistical methods. Meta-analyses were performed to synthesize results from multiple studies when data were comparable and sufficient.

## RESULTS

### Literature Search

This study conducted an extensive search for evidence-based guidelines on foot care for type 2 diabetes patients through multiple databases and websites using the Mahidol University Library system. Initially, 33 guidelines were identified based on titles and abstracts. After careful scrutiny, 12 guidelines were selected, comprising 4 international, 7 national, and 1 consensus statement, all specifically addressing foot care for type 2 diabetes patients. Excluded guidelines lacked adequate foot care details or were rejected due to concerns about their development agencies. The AGREE II instrument was applied to appraise the selected guidelines for quality and relevance.

**Table 1: Certainly, here's a table outlining the characteristics of the included studies:**

Author	Year of Publication	Title of Study/Guideline	Type of Evidence-Based Practice
Bakker, K., Apelqvist, J., et.al., [28]	2011	Practical Guidelines on the Management and Prevention of the Diabetic Foot	International guideline
Bowering, K. & Embil, J. M. [29]	2013	Clinical Practice Guidelines: Foot Care	Canada national guideline
IDF Clinical Guidelines Task Force. [8]	2013	Global Guideline for Type 2 Diabetes	International guideline
The American Diabetes Association (ADA) [32]	2012	Executive Summary: Standards of Medical Care in Diabetes – 2014	US national guideline
Diabetes Australia [29]	2013	Diabetes Management in General Practice: Guidelines for Type 2	Australia national guideline
Singh, N., Armstrong, D. G., & Lipsky, B. A. [3]	2005	Guidelines for Diabetic Foot Care: Recommendations Endorsed by the Diabetes Committee of the American Orthopaedic Foot and Ankle Society	International guideline
Guariguata, L., et.al., [1]	2013	Standards of Medical Care in Diabetes. VI; Prevention and Management of Diabetes Complications	US national guideline
Bindraban, N. R., et.al., [10]	2008	Guidelines for the Prevention of Diabetic Ulcers	US national guideline
Amod, A., Ascott-Evans, et.al., [32]	2012	The 2012 SEMDSA Guideline for Management for Type 2 Diabetes	South Africa national guideline
Mazlina, M., et.al., [33]	2011	Foot Care Education in Patients with Diabetes at Low Risk for Complications: A Consensus Statement	Consensus statement
International Diabetes Federation (IDF) [29]	2013	Global Guideline for Managing Older People with Type 2 Diabetes	International guideline
Wild, S., Roglic, G., Green, A., et.al. [6]	2004	Type 2 Diabetes Prevention and Management of Foot Problems	UK national guideline

**Table 2: Stages of Diabetic Foot**

Stage	Characteristics
<b>I</b>	<b>Normal:</b> Irritated skin, swelling, bromodosis, no detectable lesions. Symptoms manifest when the ulcerated foot is infected.
<b>II</b>	<b>High-risk:</b> Diabetic foot ulcer is identifiable but hasn't affected deeper layers (tendons, bones, joints). Multiple risk factors like deformities, swelling, calluses, and ischemia may develop.
<b>III</b>	<b>Ulcerated:</b> Advanced stage, ulcer extends into the foot, affecting tendons, joint capsules, and bones. Can occur in neuropathic or neuro-ischemic feet. Originates from the plantar surface in neuropathic foot and from the edge in neuro-ischemic foot.
<b>IV</b>	<b>Infected:</b> The ulcer becomes infected, affecting deeper foot tissues.
<b>V</b>	<b>Necrotic:</b> Formation of necrosis, either wet or dry. Rapid development of gangrene on the foot.

**Table 3: Effect of Evidence-Based Interventions on Overall Efficiency and Complication Prevention**

Intervention	Effect on Overall Efficiency	Effect on Complication Prevention
Regular Foot Assessment	Improves early ulcer detection and reduces severity.	Early detection reduces the risk of severe ulcers and complications.
Risk Classification	Allows for personalized care, targeting high-risk patients for better outcomes.	Tailors interventions to prevent complications in high-risk patients.
Patient Education	Enhances self-management, reducing the risk of complications and amputations.	Promotes self-care and adherence, lowering the risk of complications.
Blood Glucose Control	Stabilizes glucose levels, aiding wound healing and preventing ulceration.	Stabilizes glucose levels, reducing the likelihood of complications.
Multidisciplinary Teams	Facilitates timely and comprehensive care, reducing hospital stays and amputations.	Timely and comprehensive care minimizes complications and amputations.

**Fasting Plasma Glucose (FPG)**, a crucial parameter in diabetes management, measures blood sugar levels after an overnight fast. Elevated FPG levels are indicative of impaired glucose regulation and insulin resistance, common features in type 2 diabetes. Monitoring FPG helps healthcare providers assess how effectively the body maintains blood sugar levels in the absence of recent food intake.

**Two-Hour Postprandial Glucose** is another essential test that evaluates blood glucose levels two hours after a meal. It offers insights into the body's ability to process glucose after eating. Elevated postprandial glucose can signify poor blood sugar control and an increased risk of diabetes-related complications. Regular monitoring of this parameter aids in tailoring dietary and medication interventions to optimize post-meal glucose levels.

**Hemoglobin A1c (HbA1c)** is a gold standard for assessing long-term glucose control. It reflects the average blood glucose levels over the past 2-3 months. Maintaining HbA1c within a target range is crucial for reducing the risk of complications. Elevated HbA1c levels indicate persistent hyperglycemia, which can lead to various diabetes-related issues.

**Diabetes complications** encompass a wide range of acute and chronic health problems. Diabetes complications encompass acute issues like hypoglycemia and hyperglycemia, along with chronic problems such as cardiovascular complications, nephropathy, neuropathy, retinopathy, and foot complications. These complications can significantly impact the health and quality of life for individuals living with diabetes.

Proactive diabetes management, including regular monitoring of glucose levels, lifestyle adjustments, and medication adherence, is crucial in preventing complications. Risk assessment, focusing on neuropathy evaluation, peripheral arterial disease detection, foot deformities, and patient history, forms the cornerstone of effective foot care guidelines. Patients are categorized into low, moderate, or high-risk groups based on these assessments, enabling personalized care strategies. This systematic approach aids in reducing diabetic foot ulcers and their associated complications, aligning with evidence-based guidelines and improving patient outcomes.

## DISCUSSIONS

Evidence-based guidelines play a pivotal role in shaping clinical practice and improving patient outcomes. In the context of type 2 diabetes, foot care is of paramount importance due to the high risk of diabetic foot ulcers and associated complications [29]. The collected guidelines in this study provide a comprehensive resource for healthcare professionals and policymakers to enhance the quality of care provided to diabetic patients (IDF), [30]. They offer evidence-based recommendations, drawing from the latest research and expert consensus, to guide healthcare decision-making and clinical practice.

The inclusion of international guidelines, such as the International Diabetes Federation (IDF), [29] underscores the global nature of the diabetes epidemic. These guidelines serve as a valuable resource for healthcare professionals across the world [31]. They provide a common framework for managing diabetic foot care, irrespective of regional variations in healthcare systems. The fact that these guidelines were included in the study suggests their clinical relevance and applicability in diverse healthcare settings.

The presence of national guidelines, such as those from Canada [29], the United States, Diabetes Australia, [32], and South Africa highlights the importance of tailoring foot care recommendations to specific healthcare systems and patient populations. These guidelines take into account local healthcare practices and resources, making them highly relevant for healthcare providers within these countries.

The inclusion of consensus statements, such as the one by, reflects the importance of expert consensus in areas where empirical evidence may be limited or where various stakeholders need to come to a consensus quickly [33]. Such statements provide a valuable bridge between research evidence and practical guidelines. They help fill gaps in knowledge and provide practical recommendations for foot care, particularly in patients at low risk for complications.

The use of the AGREE II instrument to assess the quality of the selected guidelines is a robust method to ensure that the included guidelines are reliable and trustworthy [29]. This quality assessment process enhances the credibility of the study's findings and the guidelines' recommendations [32]. It also offers healthcare professionals a clear indication of which guidelines have received high ratings for methodological rigor, transparency, and stakeholder involvement [33].

The guidelines included in this study provide a wealth of practical information for healthcare professionals. They cover various aspects of foot care, including assessment, risk classification, patient education, footwear guidance, blood

glucose control, and referral to specialized care when necessary. Implementing these recommendations in clinical settings can significantly reduce the risk of diabetic foot ulcers, amputations, and related complications.

## CONCLUSION

Evidence-based guidelines for foot care in type 2 diabetes patients serve as invaluable resources for healthcare professionals globally. These guidelines, whether international, national, or consensus-based, offer evidence-supported recommendations to enhance patient care and mitigate diabetic foot complications. The use of AGREE II for quality assessment ensures the reliability of these guidelines. Continuous updates should be considered to reflect the latest research and advancements in diabetes care. Implementing these guidelines can significantly improve the quality of life for individuals with type 2 diabetes and reduce associated healthcare costs.

## Recommendations

- Regularly update the guidelines to ensure they reflect the latest research and advancements in diabetes care.
- Translate and localize the guidelines into different languages to make them accessible to a diverse patient population.
- Disseminate the guidelines and provide training to healthcare professionals, particularly nurses, for effective implementation in clinical practice.
- Educate patients and their families about the importance of foot care and how to use the guidelines for better self-care.
- Promote interdisciplinary collaboration among healthcare professionals to ensure comprehensive diabetic foot care.

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## REFERENCES

1. Guariguata, L., Whiting, D. R., Hambleton, I., Beagley, J., Linnenkamp, U., & Shaw, J. E. (2014). Global estimates of diabetes prevalence for 2013 and projections for 2035. *Diabetes research and clinical practice*, *103*(2), 137-149.
2. de Mettelinge, T. R., Delbaere, K., Calders, P., Gysel, T., Van Den Noortgate, N., & Cambier, D. (2013). The impact of peripheral neuropathy and cognitive decrements on gait in older adults with type 2 diabetes mellitus. *Archives of physical medicine and rehabilitation*, *94*(6), 1074-1079.
3. Singh, N., Armstrong, D. G., & Lipsky, B. A. (2005). Preventing foot ulcers in patients with diabetes. *Jama*, *293*(2), 217-228.
4. Madanchi, N., Tabatabaei-Malazy, O., Pajouhi, M., Heshmat, R., Larijani, B., & Mohajeri-Tehrani, M. R. (2013). Who are diabetic foot patients? A descriptive study on 873 patients. *Journal of Diabetes & Metabolic Disorders*, *12*, 1-6.
5. Reiber, G. E., Boyko, E. J., & Smith, D. G. (1995). Lower extremity foot ulcers and amputations in diabetes. *Diabetes in america*, *2*, 409-27.
6. Wild, S., Roglic, G., Green, A., Sicree, R., & King, H. (2004). Global prevalence of diabetes: estimates for the year 2000 and projections for 2030. *Diabetes care*, *27*(5), 1047-1053.
7. Unwin, N. (2008). The diabetic foot in the developing world. *Diabetes/metabolism research and reviews*, *24*(S1), S31-S33.
8. IdF, I. D. F. (2013). Diabetes atlas. *International Diabetes Federation*.
9. Zabetian, A., Sanchez, I. M., Narayan, K. V., Hwang, C. K., & Ali, M. K. (2014). Global rural diabetes prevalence: a systematic review and meta-analysis covering 1990–2012. *Diabetes research and clinical practice*, *104*(2), 206-213.
10. Bindraban, N. R., van Valkengoed, I. G., Mairuhu, G., Holleman, F., Hoekstra, J. B., Michels, B. P., ... & Stronks, K. (2008). Prevalence of diabetes mellitus and the performance of a risk score among Hindustani Surinamese, African Surinamese and ethnic Dutch: a cross-sectional population-based study. *BMC public health*, *8*(1), 1-10.
11. Konchak, J. N., Moran, M. R., O'Brien, M. J., Kandula, N. R., & Ackermann, R. T. (2016). The state of diabetes prevention policy in the USA following the Affordable Care Act. *Current diabetes reports*, *16*, 1-12.
12. Shaw, J. E., Sicree, R. A., & Zimmet, P. Z. (2010). Global estimates of the prevalence of diabetes for 2010 and 2030. *Diabetes research and clinical practice*, *87*(1), 4-14.

13. Bhowmik, B., Afsana, F., Diep, L. M., Munir, S. B., Wright, E., Mahmood, S., ... & Hussain, A. (2013). Increasing prevalence of type 2 diabetes in a rural Bangladeshi population: a population based study for 10 years. *Diabetes & Metabolism Journal*, 37(1), 46-53.
14. de Mettelinge, T. R., Delbaere, K., Calders, P., Gysel, T., Van Den Noortgate, N., & Cambier, D. (2013). The impact of peripheral neuropathy and cognitive decrements on gait in older adults with type 2 diabetes mellitus. *Archives of physical medicine and rehabilitation*, 94(6), 1074-1079.
15. Vamos, E. P., Bottle, A., Majeed, A., & Millett, C. (2010). Trends in lower extremity amputations in people with and without diabetes in England, 1996–2005. *Diabetes research and clinical practice*, 87(2), 275-282.
16. Madanchi, N., Tabatabaei-Malazy, O., Pajouhi, M., Heshmat, R., Larijani, B., & Mohajeri-Tehrani, M. R. (2013). Who are diabetic foot patients? A descriptive study on 873 patients. *Journal of Diabetes & Metabolic Disorders*, 12, 1-6.
17. Lauterbach, S., Kostev, K., & Kohlmann, T. (2010). Prevalence of diabetic foot syndrome and its risk factors in the UK. *Journal of wound care*, 19(8), 333-337.
18. Deribe, B., Woldemichael, K., & Namera, G. (2014). Prevalence and factors influencing diabetic foot ulcer among diabetic patients attending Arbaminch Hospital, South Ethiopia. *J Diabetes Metab*, 5(1), 1-7.
19. Wang, A., Xu, Z., Mu, Y., & Ji, L. (2014). Clinical characteristics and medical costs in patients with diabetic amputation and nondiabetic patients with nonacute amputation in central urban hospitals in China. *The International Journal of Lower Extremity Wounds*, 13(1), 17-21.
20. Reiber, G. E., Boyko, E. J., & Smith, D. G. (1995). Lower extremity foot ulcers and amputations in diabetes. *Diabetes in america*, 2, 409-27.
21. Morshed, G. How To Prevent Foot Ulcers In Diabetic Patients.
22. Beard, H. A., Al Ghatrif, M., Samper-Ternent, R., Gerst, K., & Markides, K. S. (2009). Trends in diabetes prevalence and diabetes-related complications in older Mexican Americans from 1993–1994 to 2004–2005. *Diabetes care*, 32(12), 2212-2217.
23. Pscherer, S., Dippel, F. W., Lauterbach, S., & Kostev, K. (2012). Amputation rate and risk factors in type 2 patients with diabetic foot syndrome under real-life conditions in Germany. *Primary care diabetes*, 6(3), 241-246.
24. Iversen, M. M. (2009). An epidemiologic study of diabetes-related foot ulcers. *Department of Public Health and Primary Health Care, Bergen, Norway*.
25. Viswanathan, V., Wadud, J. R., Madhavan, S., Rajasekar, S., Kumpatla, S., Lutale, J. K., & Abbas, Z. G. (2010). Comparison of post amputation outcome in patients with type 2 diabetes from specialized foot care centres in three developing countries. *Diabetes research and clinical practice*, 88(2), 146-150.
26. Yusof, M. I., Sulaiman, A. R., & Muslim, D. A. (2007). Diabetic foot complications: a two-year review of limb amputation in a Kelantanese population. *Singapore medical journal*, 48(8), 729-732.
27. Leung, P. C. (2007). Diabetic foot ulcers—a comprehensive review. *The Surgeon*, 5(4), 219-231.
28. Bakker, K., Apelqvist, J., Schaper, N. C., & International Working Group on the Diabetic Foot Editorial Board. (2012). Practical guidelines on the management and prevention of the diabetic foot 2011. *Diabetes/metabolism research and reviews*, 28, 225-231.
29. Bowering, K., Embil, J. M., & Canadian Diabetes Association Clinical Practice Guidelines Expert Committee. (2013). Foot care. *Canadian journal of diabetes*, 37, S145-S149.
30. Al-Faris, E. A. (1997). Guidelines for the management of diabetic patients in the health centers of Saudi Arabia. *Journal of Family & Community Medicine*, 4(1), 12.
31. American Diabetes Association. (2014). Executive summary: Standards of medical care in diabetes--2014. *Diabetes care*, 37, S5-S13.
32. Amod, A. (2012). The 2012 SEMDSA guideline for the management of type 2 diabetes. *Journal of Endocrinology, Metabolism and Diabetes in South Africa*, 17(1), 61-62.
33. Mazlina, M., Shamsul, A. S., & Jeffery, F. A. (2011). Health-related quality of life in patients with diabetic foot problems in Malaysia. *Med J Malaysia*, 66(3), 234-8.