Evening Medical Update: Rash, Limb Pain and Swelling
Tuesday 26 May 2020

Leg attack and foot sepsis – Mr Russell Jamieson

Are DOACs better than antiplatelet for prevention of leg attack?
The current NICE UK Guidelines for the prevention of an occlusive event are:

Clopidogrel is recommended as an option to prevent occlusive vascular events for people who have had an ischaemic stroke or who have peripheral arterial disease or multilevel disease.

Rivaroxaban plus aspirin is recommended within its marketing authorisation, as an option for preventing atherothrombotic events in adults with coronary artery disease or symptomatic peripheral artery disease who are at high risk of ischaemic events.

For people with coronary artery disease, high risk of ischaemic events is defined as:
aged 65 or over, or atherosclerosis in at least 2 vascular territories (such as coronary, cerebrovascular, or peripheral arteries), or 2 or more of the following risk factors: current smoking, diabetes, kidney dysfunction with an estimated glomerular filtration rate (eGFR) of less than 60 ml/min (note that rivaroxaban is contraindicated if the eGFR is less than 15 ml/ min), heart failure, previous non-lacunar ischaemic stroke.

What is your test of choice in day-to-day clinical practice in patients with diabetic foot ulcers? Plain X-ray or MRI to look for osteomyelitis?
A single plain X-ray is usually sufficient to reveal significant osteomyelitis. If the clinical suspicion is low and the initial plain X-ray appears normal, a repeat X-ray at 2 weeks can often demonstrate progression of any suspected area of osteomyelitis.

If the clinical suspicion is high and confirmation of osteomyelitis will change management then we do occasionally obtain a MRI. I have found that the MRI scans can be challenging to interpret as they often detect subtle marrow oedema and minor changes which may or may not be osteomyelitis and it is important to consider the "big picture" rather than simply the scan report. MRI is helpful in detecting deep soft tissue infection or collections.

Are there any side effects in the rivaroxaba n+ aspirin versus aspirin (2019) trial?
The bleeding risk was elevated in the combine therapy cohort but fatal bleeding events were similar.

When should a patient be mobilised and allowed to have physiotherapy after revascularisation surgery?
All our vascular patients are seen and assessed by our vascular surgery physiotherapy team prior to discharge. Mobilisation depends on the extent of surgery. Most lower limb operations involved incisions across or near joints, so care is required to avoid disrupting the wound. Vascular patients in general have reduced potential for wound healing as a result of their comorbidities. Our patient cohort have often become significantly deconditioned as a result of their peripheral arterial disease and comorbidity reducing their exercise potential and as result extensive long-term physiotherapy is required to build strength.

If you are unsure how much mobilisation is safe and what the physiotherapy requirement will be required post-discharge I would recommend contacting your vascular unit and discussing each patient on case-by-case basis.

Regarding the timely referral of DM foot ulcer patients – who are often seen by podiatry – how do we assess when vascular referral should be made?

In our hospital all patients with diabetic foot ulceration are referred to the diabetic podiatry team in the first instance. We a fortunate to have a close working relationship with the diabetic podiatry team and they will contact us early should there be concerns regarding peripheral arterial disease contributing to the ulceration.

If it is clear from the presentation that peripheral arterial disease is present (established gangrene/previous peripheral arterial disease treatment) then direct referral to vascular surgery would be more appropriate.

In many UK hospitals there is a move towards a "combined" diabetic foot clinic with a multidisciplinary team including podiatry, diabetes, vascular, orthopaedics, orthotics and dedicated imaging services.

Why is there not much public awareness of leg attack? And is this being addressed?
Vascular Surgery remains a "Cinderella" speciality with poor public awareness. Traditionally our patient cohort has been elderly, often from socially disadvantaged groups, less vocal and have what may be perceived as a "self-inflicted" condition as a result of smoking. As more patients with diabetes present to vascular the profile of our work is beginning to change with a more vocal, younger patient cohort championing the dangers of peripheral arterial disease.

The Circulation Foundation Charity https://www.circulationfoundation.org.uk seeks to promote awareness of peripheral arterial disease. Hopefully my talk will have raised some awareness within the RCPEd audience.

Purpura – differentials, diagnosis and management – Dr Julia Anderson

Is it correct that purpura Vs ecchymosis will aid to differentiate between platelet disease Vs coagulopathy?
Yes: platelet disorders will tend to present when the platelet count falls under about 20 x 10/L with a petechial rash and mucosal bleeding, and acquired coagulation problems such as acquired haemophilia A, will present with ecchymoses.

My initial reaction to purpura fulmonai was NAI, how do you differentiate?
NAI must always be considered in a child who presents with unexplained bruising – particularly bruising over the face and neck, as bruising in common in children of different ages usually over the upper and lower limbs. To diagnose NAI there needs to be very careful exclusion of any type of underlying bleeding disorder, particularly if the FBC and coagulation screen are normal – which is why a special set of blood tests are taken and centrifuged to ensure plasma is saved and frozen to avoid multiple venepunctures in a child and to enable specialist tests – such as flow cytometry to exclude congenital platelet dysfunction, to be evaluated. The pattern of bruising is most important, but I am not an expert in this area.

Does Purpura fulminans underlie the bleeding that occurs in the mucosa in inflammatory bowel disease?
Thank you for the question: I am not sure if the bleeding occurs due to an underlying issue with the vascular endothelium that is abnormal rather than due to a specific platelet function problem.