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Diabetic Foot Complications

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Introduction

Diabetes is the most common disease in the world with an increase of 6 to 11% in developed countries and up to 30% in developing countries. Although its growth rate increases with age, it is increasingly increasing in the active age group. Diabetic foot ulcers are often associated with diabetic retinopathy, with a lifetime risk of up to 25%. Diabetic foot infections (DFIs) usually start in infected DFUs where more than half of DFUs are infected. However, DFIs can occur without pre-existing DFUs. All wounds are contaminated with germs. When bacteria attach to the tissues and multiply, a colonic condition exists where host resistance is still important. As soon as the combined bacteria cause local damage to the tissue, the condition of the local infection is often referred to as a critical colony. A large number of bacteria in the critical colonial stage may delay healing and lead to deep and surrounding tissue infections when host resistance is at risk. DFIs are associated with an increase in morbidity, mortality, hospitalization rates, amputations and costs. It is also associated with a significant decline in people's working conditions and their mental well-being. There is a tenfold increase in the rate of hospitalization with skeletal and soft tissue that is transmitted to people with diabetes than to those without diabetes. Globally, lower extremity amputations are mainly caused by diabetes where the risk of amputation of the lower extremities has increased by 20 percent in diabetic patients and 25- 90% of worldwide amputations are associated with diabetes. It is easy to imagine the current burden of health care costs from DFIs and the need to improve patient health quality and lower health care costs with early diagnosis and management of DFIs. The thoughtful use of systemic antimicrobial s is important for all health care professionals because their use is one of the key components of the treatment of DFIs. Wound care professionals need to quantify concerns about the overuse of antimicrobial systemic and improved outcomes for chronic wound with long-term long-term treatment. This article reviews antimicrobial treatment as an important part of the management of DFIs. Antimicrobial therapy is one of the key arms treatments for DFIs. There are two types of antimicrobial treatment for DFIs: effective and directed treatment. Antibiotic treatment should be started after taking all the appropriate cultures. Knowing that all skin lesions contain microorganisms, diseases should be diagnosed clinically rather than microbiologically. Patients with an infected foot ulcer may therefore reduce the symptoms of an inflammatory response possibly due to peripheral neuropathy or ischemia. The effects of advanced antimicrobial treatment occur when independent organisms are treated with antimicrobial drugs that have a positive effect on tissue penetration. Physicians should always keep in mind that cultures may not always recognize all pathogens and unless special precautionary measures are taken, the anaerobes present in the wound may not be reflected in the bacterial culture effect. Other considerations to consider when choosing antimicrobials for the treatment of DFIs include administrative frequency, intestinal tract function, potential side effects, drug interactions, costs, and patient history of comorbid allergies such as renal and hepatic disease. Symptoms of a toxic system are not uncommon in diabetic foot infections. Many patients are burned to the bone without the number of high white blood cells, or a measure of the formation of high lesions, or a protein that works with C and does not report pain. If any of these symptoms are present, then a serious infection may be present. However, in patients with severe DFIs and hemodynamic instability, antiricicial treatment should begin as soon as possible, even before taking appropriate doses if they are to be delayed. Neuropathy and immunopathy are the main causes of infection in patients. Often vascular disease is associated with neuropathy which plays a major role in the healing power. Neuropathy puts a foot on infection while vasculopathy and immunopathy determine the results. Evidence of an autoimmune disorder has been found, including the accumulation of intraneural sorbitol and glycosylation of nerve proteins and the reduction of axonal transport. Loss of self-esteem, combined with recurrent trauma, is a major cause of muscle wasting in the foot. The surgical method of infection will depend on the site of its entry. More often than not, the incisional pathway will follow the extensor or flexor tendon of the foot. If possible, a clean biopsy and culture should be obtained to obtain specific physical therapy. In wounds with strong evidence of infection, the first empiric type should take into account the severity of the infection and etiologic agents. Comprehensive antibiotic treatment should be reserved for serious diseases and should be minimized depending on the results of culture and antibiotic availability data. Acute DFI will follow the tender approach to tender footwork. Diabetes mellitus is a common source of illness, disability, and loss of limbs. Diabetes foot infections are difficult to treat because the etiology is multifaceted. Systematic and multi-sectoral approaches are important in preventing and directing treatment. Symptoms of the infection system are often misleading. In patients with peripheral neuropathy, a large proportion of foot infections and associated illnesses can be prevented with careful observation, and preventive measures. Surgery management is a pillar of moderate and severe infection, and early detection is the key to success.

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Conflict of Interest

The authors declare that there is no conflict of interest.