

# Multidisciplinary Approach to Save and Salvage the Lower Limb in Diabetic Foot Disease: A Retrospective Study of Eight Years Procedures and outcome in South-South Nigeria

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## ABSTRACT

**Introduction:** A multidisciplinary approach is the gold standard for saving limbs in diabetic foot disease, reducing major amputations by up to 50–77.8% and improving wound healing times. Because diabetic foot ulcers arise from a complex interplay of peripheral neuropathy, vascular disease, and infection, managing them requires the coordinated expertise of multiple specialties to address perfusion, infection, offloading, and metabolic control. The objective of this study was to evaluate the outcome of multidisciplinary care on saving the diabetic foot.

**Methods:** Hospital base retrospective study of patients with diabetic foot, from October 2018 to 31st December, 2025. Information for each patient were retrieved from the hospital records. These were the subjects that were referred to the hospitals i.e. Bayelsa Specialist Hospital, Yenagoa, Save a Life hospital, and Anderson Hospital, Port Harcourt. Data analysis was done with SPSS version 25.

**Results:** A total of 68 participants were included in the study. Most of the respondents were male (57.4%). Most patients (80.9%) had limb salvage, while 19.1% underwent amputation. The mean age of patients who underwent amputation ( $76.36 \pm 6.38$  years) was significantly lower than that of patients whose limbs were saved ( $60.62 \pm 8.78$  years), and this difference was statistically significant ( $p = 0.001$ ). A large proportion of patients aged >75 years (76.9%) underwent amputation, whereas none of the patients aged 65–75 years had amputations (63.7% limb salvage). Among patients aged <65 years, the majority had limb salvage, while only 7.8% underwent amputation. Among patients who presented early ( $\leq 1$  week), only 4.2% underwent amputation, while 95.8% had limb salvage. In contrast, among those who presented late (>1 week), 55.0% underwent amputation, and only 45.0% had limb salvage

**Conclusion:** The management of diabetic foot disease require careful assessment by the team which comprises of vascular surgeons, interventionalist, biomechanical foot abnormalities by the podiatrist, wound coverage by the plastic surgeons and aggressive treatment of infections and metabolic derangements by the physicians are required. The multidisciplinary approach provides a comprehensive treatment protocol and significantly increases the chances of successfully healing the ulcer and prevents recurrence.

**Keywords:** Multidisciplinary; Approach; Severe; Peripheral Artery; Disease; Critical Limb Ischemia

**Abbreviations:** DM: Diabetes Mellitus; IDF: International Diabetes Federation; CLTI: Chronic Limb-Threatening Ischemia; PAD: Peripheral Artery Disease; HRQL: Health-Related Quality of Life; CLI: Critical Limb Ischemia; BMI: Body Mass Index; EVT: Endovascular Therapy

## Introduction

Diabetes mellitus (DM) is a major public health problem with growing concern. The predominant form globally is type 2 diabetes, which accounts for about 95% of cases [1]. The International Diabetes Federation (IDF) estimated in 2024 that 588.7 million people worldwide had type 2 diabetes, with an expected rise to 852.5 million people by 2050.1 24.6 million adults aged 20–79 years were estimated to have diabetes in Africa, while Nigeria was estimated to have 1.7 million citizens living with diabetes in 2024. [1,2] The South-South geopolitical zone of Nigeria has the highest prevalence (9.8%) of diabetes among the six geopolitical zones of Nigeria [3]. Chronic limb-threatening ischemia (CLTI) represents the end stage of peripheral artery disease (PAD), a problem of growing prevalence and increased health care costs around the globe [4]. CLTI is a highly morbid disease, incurring significant mortality, limb loss, pain, and diminished health-related quality of life (HRQL) among those afflicted [4]. Multidisciplinary teams are necessary to treat complex patients with chronic limb-threatening ischemia (CLTI) [4,5]. The need for adequate wound care and control of comorbid conditions cannot be accomplished by the vascular specialist alone [4,6]. Numerous specialties have a role in this group to include surgical podiatrists, orthopedic surgery, plastic and reconstructive surgery endocrinology, and wound care.6 However, the vascular specialist must drive this team as the patients are usually referred to them and numerous studies have shown a direct correlation between major amputations and the lack of vascular involvement [4,5].

Creating these teams is unique in each community and hospital and must consider practice patterns that are relevant in the local region. CLTI is a challenging disease to manage, and multidisciplinary teams have demonstrated an ability to improve outcomes and deliver superior care to this patient population [6]. The objective of this study was to evaluate the outcome of multidisciplinary care of saving the diabetic foot.

## Methods

### Study Design

**Study Population and Design:** This included type two diabetes mellitus complicated with critical limb ischemia. Hospital base retrospective study of patients with diabetic foot involving from 1st October 2018 to 31st December, 2025. Information for each patient were retrieved from the hospital records. These were the subjects that were referred to the hospitals i.e. Bayelsa Specialist Hospital, Yenagoa, Save a Life hospital, and Anderson Hospital, Port Harcourt. Definition of critical limb ischemia: Critical limb ischemia (CLI), now often termed Chronic Limb-Threatening Ischemia (CLTI), is an advanced stage of peripheral artery disease (PAD) defined by severe, chronic blockage in lower extremity arteries [7]. The term critical limb ischemia refers to a condition characterized by chronic ischemic at-rest pain, ulcers,

or gangrene in one or both legs attributable to objectively proven arterial occlusive disease. Critical limb ischemia implies chronicity and is to be distinguished from acute limb ischemia [7].

**Inclusion and Exclusion Criteria:** included subjects

All the subjects with complete data in their records managed in the three hospitals above were included for the stated period.

All the subjects with incomplete data in their records managed in the three hospitals above were excluded for the stated period.

**Ethical Approvals:** The ethical approval from the three hospitals were gotten for the study.

**Data Analysis:** Data for this study were entered, cleaned, and analyzed using statistical software (SPSS) version 25. The dataset was checked for completeness and consistency before analysis, and variables were appropriately coded. Continuous variables were assessed for normality prior to analysis.

Descriptive statistics were used to summarize the characteristics of the study population. Continuous variables such as age, weight, height, and body mass index (BMI) were presented as mean  $\pm$  standard deviation, as well as median and range where applicable. Categorical variables including sex, age categories, BMI categories, risk factors, arterial status, treatment modalities, and patient outcomes were summarized using frequencies and percentages. Pie charts were used to illustrate key proportions, including the distribution of endovascular therapy, hybrid therapy, and patient outcomes. Inferential analysis was conducted to determine associations between independent variables and patient outcomes (limb salvage versus amputation). The independent samples t-test was used to compare the means of continuous variables between outcome groups. The chi-square test was used to assess associations between categorical variables and patient outcomes. A p-value of less than 0.05 was considered statistically significant. All results were presented in tables and figures and interpreted accordingly.

## Results

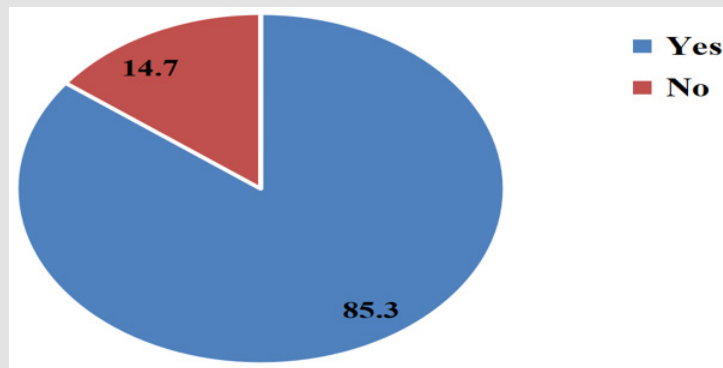
The socio-demographic characteristics of the respondents are presented in Table 1. A total of 68 participants were included in the study. The majority of the respondents were male (57.4%), while 42.6% were female, indicating a slight male predominance. Regarding age distribution, more than half of the respondents (55.9%) were aged above 75 years, followed by those aged 65–75 years (26.5%), while only 17.6% were younger than 65 years. The mean age of the study population was  $73.35 \pm 9.25$  years, with a median of 76 years, suggesting that the study population was largely elderly. In terms of body mass index (BMI), the majority of respondents were overweight (67.6%), while 26.5% were obese, and only 5.9% had normal BMI.

**Table 1:** Socio-demographic characteristics of the study population.

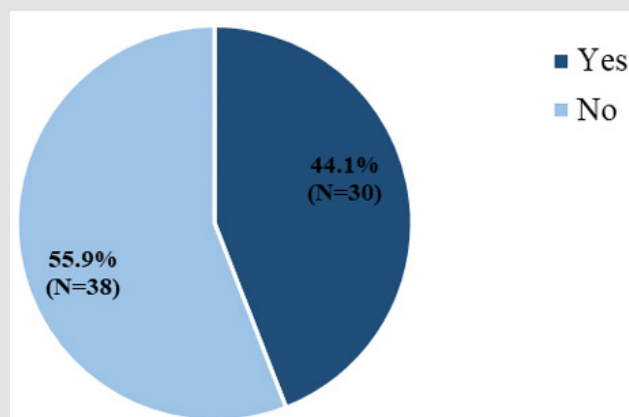
Variables	Frequency N=68	Percentage %
<b>Sex</b>		
Male	39	57.4
Female	29	42.6
<b>Age</b>		
<65years	19	27.9
65 - 75years	37	54.4
>75years	12	17.7
<b>Body Mass Index</b>		
Normal	4	5.9
Overweight	46	67.6
Obese	18	26.5

Table 2 shows other clinical characteristics of the respondents. Regarding risk factors, 42.6% of the respondents had Type 2 Diabetes Mellitus (T2DM) alone. Meanwhile, 29.4% had T2DM coexisting with

hypertension, and 27.9% had T2DM with dyslipidemia. Assessment of vascular status showed that most respondents had normal findings in several arterial segments. In the common iliac artery, 88.2% were normal, while 11.8% had 100% occlusion. For the external iliac artery, 72.1% were normal, whereas 27.9% had less than 100% occlusion. Similarly, in the common femoral artery, 76.5% of respondents had normal findings, while 23.5% had 100% occlusion. In the superficial femoral artery, 55.9% were normal, 27.9% had 100% occlusion, and 16.2% had less than 100% occlusion. Findings for Popliteal Artery showed that 33.8% were normal, 50.0% had less than 100% occlusion, and 16.2% had 100% occlusion. As shown in the Figure 1 below, the majority of respondents (85.3%) underwent endovascular therapy, while only 14.7% did not receive this intervention. Figure 2 indicates that 44.1% of respondents underwent hybrid therapy, whereas 55.9% did not. The outcomes of revascularization are presented in Figure 3. The majority of patients (80.9%) had limb salvage, while 19.1% underwent amputation. Table 3 compares selected continuous variables with patient outcomes. The mean age of patients who underwent amputation ( $76.36 \pm 6.38$  years) was significantly lower than that of patients whose limbs were saved ( $60.62 \pm 8.78$  years), and this difference was statistically significant ( $p = 0.001$ ).



**Figure 1:** Pie chart showing proportion with endovascular therapy.



**Figure 2:** Pie chart showing proportion of hybrid therapy patients in the study.

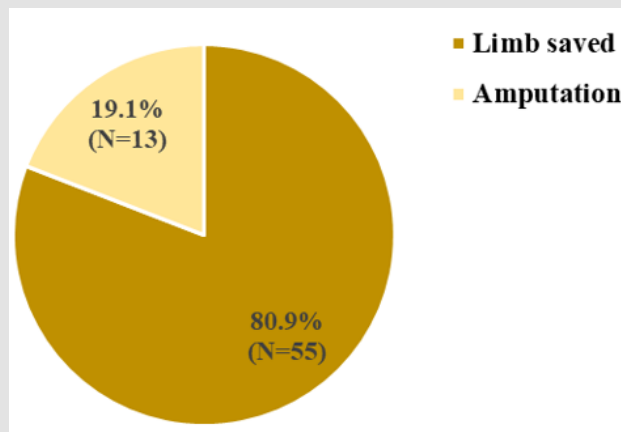


Figure 3: Outcome of revascularization.

Table 2: Characteristics of the study population.

Variables	Frequency N=68	Percentage %
<b>Risk</b>		
Type 2 Diabetes Mellitus	29	42.6
Type 2 Diabetes Mellitus & Dyslipidemia	19	27.9
Type 2 Diabetes Mellitus & Hypertension	20	29.4
<b>Common Iliac Artery</b>		
100% Occlusion	8	11.8
Normal	60	88.2
<b>External Iliac Artery</b>		
<100% Occlusion	19	27.9
Normal	49	72.1
<b>Common Femoral Artery</b>		
100% Occlusion	16	23.5
Normal	52	76.5
<b>Superficial Femoral Artery</b>		
<100% Occlusion	11	16.2
100% Occlusion	19	27.9
Normal	38	55.9
<b>Popliteal Artery</b>		
<100% Occlusion	34	50
100% Occlusion	11	16.2
Normal	23	33.8

Table 3: Comparison of continuous variables with patient outcome.

Variables (N=68)	Outcome		t	p-value
	Amputation Mean ± SD	Limb Saved Mean ± SD		
Age	76.36 ± 6.38	60.62±8.78	7.425	0.001*
Height	1.71 ± 0.06	1.72 ± 0.08	0.374	0.71
Weight	78.46 ± 0.88	87.25 ± 11.62	2.712	0.009*
Body Mass Index	26.80 ± 1.48	29.89 ± 6.79	1.626	0.109

Note: \*Statistically Significant.

Similarly, weight was significantly associated with outcome, with patients who had limb salvage having a higher mean weight (87.25 ± 11.62 kg) compared to those who underwent amputation (78.46 ± 0.88 kg) (p = 0.009).

However, there was no statistically significant difference in height (p = 0.710) and BMI (p = 0.109) between the two outcome groups. Table 4 shows a statistically significant association between age category and patient outcome (p = 0.001). A large proportion of patients aged >75 years (76.9%) underwent amputation, whereas none of the patients aged 65–75 years had amputations (63.7% limb salvage). Among patients aged <65 years, the majority had limb salvage, while only 7.8% underwent amputation. There was a statistically significant association between BMI and patient outcome (p = 0.029). Among patients with normal BMI, 25.0% underwent amputation, while 75.0% had limb salvage. In the overweight group, 26.1% had amputations, while 73.9% had limb salvage. It was also observed that none of the obese patients underwent amputation (100% limb salvage). This is shown in Table 5. Table 6 shows a strong statistically significant as-

sociation between endovascular therapy and patient outcome ( $p = 0.001$ ). Among patients who received endovascular therapy, 94.8% had limb salvage, while only 5.2% underwent amputation. There was a statistically significant association between hybrid therapy and outcome ( $p = 0.001$ ). Among patients who underwent hybrid therapy, 43.3% had amputations, while 56.7% had limb salvage. In contrast, none of the patients who did not receive hybrid therapy underwent amputation (100% limb salvage). This is shown in Table 7. Table 8 shows a statistically significant association between risk factors and patient outcome ( $p = 0.001$ ). All patients with T2DM alone had limb salvage (100%). However, among patients with T2DM and dyslipidemia, 52.6% underwent amputation, indicating poorer outcomes. Similarly, in patients with T2DM and hypertension, 15.0% underwent amputation, while 85.0% had limb salvage. There was a statistically significant association between duration before presentation and patient outcome ( $p = 0.001$ ). Among patients who presented early ( $\leq 1$  week), only 4.2% underwent amputation, while 95.8% had limb salvage. In contrast, among those who presented late ( $> 1$  week), 55.0% underwent amputation, and only 45.0% had limb salvage. This is shown in Table 9.

**Table 4:** Association between age category and patient outcome.

Age category	Outcome		Total n	p-value
	Amputation n (%)	Limb Saved n (%)		
<65years	1 (7.8)	18 (32.7)	19	0.001*
65 - 75years	2 (15.4)	35 (63.7)	37	
>75 years	10 (76.9)	2 (3.6)	12	
<b>Total</b>	<b>13 (19.1)</b>	<b>55 (80.9)</b>	<b>68</b>	

Note: \*Statistically Significant.

**Table 5:** Association between body mass index and patient outcome.

Body Mass Index	Outcome		Total n (%)	p-value
	Amputation n (%)	Limb Saved n (%)		
Normal	1 (25.0)	3 (75.0)	4 (100.0)	0.029*
Overweight	12 (26.1)	34 (73.9)	46 (100.0)	
Obese	0 (0.0)	18 (100.0)	18 (100.0)	
<b>Total</b>	<b>13 (19.1)</b>	<b>55 (80.9)</b>	<b>68 (100.0)</b>	

Note: \*Statistically Significant.

**Table 6:** Association between endovascular therapy and patient outcome.

Endovascular Therapy	Outcome		Total n (%)	p-value
	Amputation n (%)	Limb Saved n (%)		
Yes	3 (5.2)	55 (94.8)	58 (100.0)	0.001*
No	10 (100.0)	0 (0.0)	10 (100.0)	
<b>Total</b>	<b>13 (19.1)</b>	<b>55 (80.9)</b>	<b>68 (100.0)</b>	

**Table 7:** Association between hybrid therapy and patient outcome.

Hybrid Therapy	Outcome		Total n (%)	p-value
	Amputation n (%)	Limb Saved n (%)		
Yes	13 (43.3)	17 (56.7)	30 (100.0)	0.001*
No	0 (0.0)	38 (100.0)	38 (100.0)	
<b>Total</b>	<b>13 (19.1)</b>	<b>55 (80.9)</b>	<b>68 (100.0)</b>	

Note: \*Statistically Significant.

**Table 8:** Association between risk and patient outcome.

Risk	Outcome		Total n (%)	p-value
	Amputation n (%)	Limb Saved n (%)		
Type 2 Diabetes Mellitus	0 (0.0)	29 (100.0)	29 (100.0)	0.001*
Type 2 Diabetes Mellitus & Dyslipidemia	10 (52.6)	9 (47.4)	19 (100.0)	
Type 2 Diabetes Mellitus	3 (15.0)	17 (85.0)	20 (100.0)	
<b>Total</b>	<b>13 (19.1)</b>	<b>55 (80.9)</b>	<b>68 (100.0)</b>	

Note: \*Statistically Significant.

**Table 9:** Association between duration before presentation and patient outcome.

Duration before presentation	Outcome		Total n (%)	p-value
	Amputation n (%)	Limb Saved n (%)		
$\leq 1$ week (Early)	2 (4.2)	46 (95.8)	48 (100.0)	0.001*
$> 1$ week (Late)	11 (55.0)	9 (45.0)	20 (100.0)	
<b>Total</b>	<b>13 (19.1)</b>	<b>55 (80.9)</b>	<b>68 (100.0)</b>	

Note: \*Statistically Significant.

## Discussion

Since the BASIL trial, Endovascular therapy has become a first-line treatment for CLTI patients with perioperative risks or comorbidities [8]. Although it has the disadvantages of high restenosis and reintervention rates, it also has the advantages of repeating the procedure until wound healing and limb salvage are achieved, the low cost and short hospital stay, and the remarkable technological advances and instrumentation developments [9]. Also, it leaves room for formation of collateral vessels. In our retrospective study, 68 patients, majority of patients (80.9%) had limb salvage, while 19.1% underwent amputation. The SPINACH registry suggested that CLTI patients with severe limb conditions would be suitable for bypass surgery. In contrast, patients in poor general conditions, such as frailty, have also been shown to benefit more from endovascular therapy (EVT) [10]. Considering the criteria of this registry, we found that both EVT and bypass surgery could be options in our 68 patients. Thirteen patients out of the 68 had amputation. The reason for the low rate of amputation was due to multidisciplinary team to the treatment of CLTI. Among the 13 patients who underwent amputation, the most common type was below-knee amputation (61.5%), followed by above-knee amputation (15.4%), while 23.1% were unspecified. The reasons for the below limb is due hybrid therapy i.e combination of endovascular and amputation that saved the knee joint.

On the other hand, some reports suggest that patients with multivessel disease should undergo endovascular revascularization rather than surgical reconstruction [11]. 44.1% of respondents underwent hybrid therapy ie endovascular and surgical bypass. Increasing age is strongly associated with poorer functional outcomes and higher mortality following endovascular thrombectomy (EVT) for acute ischemic stroke, with patients years often showing significantly lower rates of favorable outcomes (mRS 0–2) compared to younger counterparts. While older age is a significant negative predictor of functional recovery, EVT remains safe, with similar rates of successful recanalization and no significant increase in symptomatic intracranial hemorrhage (SICH) across age groups [12-13]. A large proportion of patients aged >75 years (76.9%) underwent amputation, whereas patients aged 65–75 years had amputations (63.7% limb salvage). Among patients aged <65 years, the majority had limb salvage, while only 7.8% underwent amputation. Our study showed a clear association between BMI and patient outcome ( $p = 0.029$ ). Among patients with normal BMI, 25.0% underwent amputation, while 75.0% had limb salvage. In the overweight group, 26.1% had amputations, while 73.9% had limb salvage.

Obesity is generally associated with an “obesity paradox” in endovascular procedures, often resulting in improved survival and reduced mortality despite higher comorbidities, particularly in EVAR

(endovascular aneurysm repair) and peripheral arterial disease interventions [14]. Obese patients show similar or better technical success, lower reintervention rates, and fewer long-term mortality risks compared to non-obese patients, although they face higher risks of access site infections [14]. This study demonstrated that patients who presented early ( $\leq 1$  week), only 4.2% underwent amputation, while 95.8% had limb salvage. In contrast, among those who presented after one week, 55.0% underwent amputation, and only 45.0% had limb salvage. Late presentation in patients with Peripheral Artery Disease (PAD) is strongly associated with significantly worse endovascular outcomes, including higher rates of amputation, increased mortality, and lower limb salvage rates. [16,17] Delayed diagnosis and intervention allow the disease to progress from claudication to severe Chronic Limb-Threatening Ischemia (CLTI), which limits the effectiveness of endovascular techniques [15,16].

## Conclusion

PAD is a complex disease process that requires a collaborative team of several physicians and healthcare providers to prevent major disability and mortality. Due to the vastness of the disease, a multidisciplinary approach is needed. The team include the endocrinologist, vascular surgeon, interventional cardiologist, interventional radiologist, diabetic nurse, social worker, nephrologist, etc [17]. The multidisciplinary approach provides a comprehensive treatment protocol and significantly increases the chances of successfully healing the ulcer and prevents recurrence.

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## Conflict of Interest

There is no conflict of interest.

## Informed Consent

There is a general principle of the hospital that all form of identity of subjects be kept secret. Informed consent was taken for and in the files of patients while in the hospital.

## Author Contributions

Study design and data collection was carried out by Emmanuel A Edafe. Data analysis was done by Emmanuel A Edafe. Discussion was written by Sunny Chinenye and Chioma Unachukwu.

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