An Interview with **Dr. David Armstrong**:

An International Leader in Diabetic Foot Management

Dr. David Armstrong

INTERVIEWED BY Catherine Harley, Associate Editor, *Wound Care Canada*

After graduating from The California College of Podiatric Medicine, Dr. Armstrong has held several positions in medical centres and universities in the U.S. and U.K. He also holds a Masters of Science in Tissue Repair and Wound Healing from the University of Wales College of Medicine and a PhD from the University of Manchester College of Medicine.

Dr. Armstrong is the U.S. director of the Diabetes Lower Extremity Research Group. He was selected as one of the first six International Wound Care Ambassadors and is the immediate past Chair of Scientific Sessions for the American Diabetes Association's Foot Care Council, as well as a member of the National Board of Directors of the American Diabetes Association.

Q What is your current job title?

Professor of Surgery, Chair of Research and Assistant Dean, Dr. William M. Scholl College of Podiatric Medicine at Rosalind Franklin University of Medicine and Science, Chicago.

Q How long have you been in this role?

In fact, I have just started this position. I left a wonderful several years in Tucson, where I was fortunate to work with my friend and colleague Dr. Brent Nixon to develop what has now become a truly fine diabetic-foot research unit.

Q What does your current job entail and how does it relate to wound care?

I look at my position as "Chief Inspiration Officer." In other words, I'm the luckiest foot doctor on the planet. I have the wonderful opportunity to work with students, residents and faculty, who are far smarter than I am, to figure out better ways to fix feet and heal wounds.

Q What inspires you to come to work each day?

I can't think of a day that I didn't want to come into work. What inspires me is the opportunity to inspire. Our profession has a desperate dearth of mentors. The opportunity to serve as one is, I believe, the greatest honour anyone could have. That's why, when the alarm clock rings, I'm probably already in the shower.

Q How did you get involved in diabetic foot research?

I was always interested in the diabetic foot. However, one patient comes to mind that really set it off for me. She was a lovely lady who was, quite literally, just off the plane from India. She had both leprosy and diabetes, and she presented with a small diabetic foot wound under her forefoot. It was my first day in clinic as a resident, and I thought I knew everything.

I remember beginning to debride her wound and realized that I hadn't even considered anesthetizing her. I took a step back and looked at this woman—who was peaceful as can be and completely pain-free—and had an epiphany. I realized (as so many others previously had realized) that we are born and conditioned to respond to pain. This is true of patients as well as health-care providers. The real challenge is responding to the absence of pain. I knew then and there that this was the area of medicine I wanted most to explore.

Q Any "top tips" for health-care professionals caring for patients with diabetic foot problems?

I could say only that the treatment of the absence of pain (and its sequelae) is the most challenging but ultimately rewarding area in which to practice. To the young practitioner: never, ever lose your enthusiasm. This is what keeps you, as my friend Dr. Gary Sibbald is fond of saying, "treating the whole patient rather than a 'hole' in the patient."

Q How has the management of diabetic neurotrophic ulcers changed since you got involved?

There has been an enormous

change technologically, even over the last decade. However, this has not led, in any real sense, to a reduction in amputations. The reason for this is quite simple: we have put the therapeutic cart before the therapeutic horse. We must concentrate on the central tenets of care in these patients—debridement and offloading—before we decide what to put on the wound. This mantra is bandied about at every single meeting that I attend; however, it rarely is followed as well as it should be followed. This is because we, as practitioners, compromise. We compromise in the way we debride and in the way we offload. No technology—no matter how promising—will overcome this problem. This is a problem not necessarily with education but with implementation. That is why we see large differences between clinics, often even in the same geographic region. I believe that, once this issue is resolved, many of the extraordinary technologies we now have available (and ones we will soon have) will lead to results that will be gratifying to us, our clinicians and our public health authorities.

Q Which wound-care meetings and conferences do you attend and why?

I must say it seems like I attend them all. Sometimes the most important thing one can do in terms of professional growth is just to show up.

Q Which Web sites do you use the most?

Pubmed (www.ncbi.nlm.nih.gov/entrez/query.fcgi).

Q What would make the management of diabetic foot ulcers even better?

A dose of common sense, as we have discussed above.

Q How will new technology influence the future of diabetic ulcer management?

I believe many of the most promising technologies lie not in ulcer management but in prevention. We are finding impressive results through the use of computerized activity monitors, which allow us to dose activity as we do a drug, and thermometry, which helps us spot potentially dangerous inflammation before it is palpable or obvious. These, coupled with more widespread community-wide risk-assessment, are what will lead us most dramatically to a reduction in amputations. I am hugely excited about the next five to 10 years. It is an absolutely great time to be involved in medicine in general, in wound care specifically and diabetic foot care especially.