Editorial and Mini-Review: Topical Oxygen Therapy for Diabetic Foot Ulcerations - Avenue Towards New Hope?

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Abstract

Diabetic foot complications now represent the 10th leading cause of disease burden and disability. Wound healing is impaired, leading to chronic ulceration. Local high oxygen concentration is required by the metabolically active cells in the wound, which may render the region hypoxic, even in the absence of peripheral arterial disease. Therefore, the contribution of hyperbaric oxygen to improved healing rates has been extensively investigated. More recent developments include products delivering topical oxygen therapy (TOT) directly at the wound site, either by continuous delivery or by pressurized systems. A very recent systematic review has found that TOT increases wound healing rates in chronic, less severe diabetic foot ulcers (DFUs), and it promotes high rates of healing in more severe ulcers. Thus, TOT appears to be very promising to improve healing in DFUs. We now need more experience regarding its therapeutic place in the algorithm of DFU management and in relation to optimal patient selection.

Keywords: diabetes mellitus · diabetic foot ulcer · vascular disease · topical oxygen therapy · peripheral arterial disease · wound healing

Lower-extremity complications secondary to diabetes now rank as the 10th leading cause of global disease burden and disability [1]. Up to one in 3 of subjects with diabetes are at risk of developing a diabetic foot ulcer (DFU) during their lifetime [2], a condition also associated with an increased risk of lower extremity amputation and mortality [3]. Perhaps the biggest challenge of DFUs is that they are difficult to heal. Indeed, according to the United Kingdom National Diabetic Foot Audit, less than half of all new diabetic foot ulcers are healed by 12 weeks [4]. Even in specialized centers, healing rates for DFUs amount to 22-30% at 20 weeks [5, 6].

Wound healing is a complex pathway involving a dynamic series of interactions between local cells, proteins, proteases, growth factors, and extracellular matrix components [7]. In this process, oxygen is a pivotal factor, because it is critical for cellular ATP generation, collagen deposition, fibroblast proliferation, angiogenesis, and superoxide production, which allow local tissues to resist infection [8]. Wounds can become increasingly hypoxic as a result of disruption of the vascular flow and/or the increased oxygen demands that accompany the local response to healing [8, 9]. Indeed, the high oxygen demand of metabolically active cells in the wound microenvironment may render the region hypoxic, even in the absence of peripheral arterial disease (PAD) [10].

Therefore, interventions aiming to improve local oxygen delivery hold promise for chronic wound healing. The use of hyperbaric oxygen therapy (HBOT) has received extensive academic interest and widespread clinical adoption. However, the results of several randomized clinical trials (RCTs) have been inconsistent regarding its efficacy in healing DFUs [11, 12]. Furthermore, up to one...
third of subjects considered for treatment are unsuitable or intolerant of HBOT because of comorbidities [13]. Of note, HBOT is expensive and not widely available. Hence, products delivering topical oxygen therapy (TOT) either by continuous delivery or pressurized systems have now been developed. These devices deliver oxygen topically, directly into the local injured tissue and can circumvent some of the limitations associated with HBOT. Many of these devices are portable and can even be used at home, which makes them more attractive.

In this volume of The Review of Diabetic Studies, Nataraj et al. report their findings of a systematic review of TOT on wound healing in DFUs [14]. They included studies of patients with chronic DFUs receiving TOT compared with individuals who received standard care. Overall, 5 studies were reviewed involving 80 participants. The authors concluded that the use of TOT led to a higher complete wound healing rate in chronic, less severe DFUs and also improved the percentage area reduction in more severe ulcers [14].

While the findings by Nataraj et al. are encouraging for the use of TOT, we must not ignore several limitations [14]. The first relates to the small sample size. Secondly, most studies had a brief duration of follow-up, mainly between 4-8 weeks, and only 1 study with a 12-week follow-up was included [14]. Moreover, there was significant heterogeneity between the studies in terms of inclusion criteria, duration of ulceration, DFU characteristics, previous foot care, and reporting of results [14]. Furthermore, the authors did not use the 21-point assessment criteria to evaluate the quality of studies [15]. Finally, it was not possible for the authors to conclude on the cost-effectiveness of TOT [14].

Possibly, the most important limitation, and one which may be linked to the definition of chronic DFU used by the authors (i.e. >3 months' duration) is the non-inclusion of further RCTs on TOT. One early randomized study reported no apparent reduction in the cross-sectional area of DFUs; however, it had a sample size of only 28 participants and a 2-week follow-up [16]. Another larger RCT by Driver et al., including 130 subjects, found no difference in healing rates of DFUs with TOT compared with standard care at 12 weeks [17].

By contrast, 3 studies have yielded positive results [18-20]. Niederauer et al. reported an almost two-fold higher rate (p < 0.033) of complete DFU closure at 12 weeks in 146 subjects [18]. These authors compared continuously diffused topical oxygen therapy with standard care, including the use of a sham device [18]. The same group also reported similar results with continuously diffused topical oxygen therapy in a smaller study along with the intriguing observation that the efficacy of TOT was greater in more chronic and larger wounds [19]. More recently, Frykberg et al. have reported that topical wound oxygen therapy applied with pressure varied cyclically was superior (p = 0.007) to sham therapy and standard care in achieving complete wound closure, thereby increasing the likelihood of DFU healing at 12 weeks by up to 4-fold [20].

In conclusion, TOT appears promising in terms of improving healing rates of DFUs [18-20]. Ease of use is a further advantage. Nonetheless, its precise therapeutic role in the algorithm of DFU management requires further elucidation. We also need to know more on both the optimal selection of patients and the window of therapeutic opportunity. Meanwhile, prompt recognition, early specialist referral, and intensive multidisciplinary management of DFUs remain crucial [21].

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References


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