

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Desmond A. Iyalla

DOB

02/19/1963

AGE / SEX

63 yrs / Male

MRN / PATIENT ID

3390845

DATE OF SERVICE

08/05/2026

PROVIDER

Katherine Marsh, DPM

CREDENTIALS

DPM, FACFAS

REFERRAL SOURCE

Vascular surgery — post-angioplasty limb salvage referral

VISIT TYPE

Multidisciplinary Limb Salvage Visit — week 3 after tibial angioplasty

CARE SETTING

Outpatient Limb Preservation Clinic — joint podiatry / vascular session

PRIMARY CARE PROVIDER

Nadine Fitzgerald, MD

VASCULAR SURGEON / WOUND PROVIDER

Owen Brasfield, MD — vascular surgery; co-attending this visit

CC CHIEF COMPLAINT

2 PRIMARY LIMB PRESERVATION CONCERN

"The second toe has gone completely black and the pain at night has come back. I sleep in the recliner with my leg hanging down because that's the only way it eases. Dr. Brasfield opened the artery three weeks ago and I thought that was supposed to fix it. I do not want to lose the leg — I still drive myself to dialysis."

S SUBJECTIVE

3 PATIENT-REPORTED LIMB SYMPTOMS, WOUND HISTORY & VASCULAR COURSE

3a INDICATION, WOUND & ISCHEMIA HISTORY

Reason for Limb Preservation Evaluation

Multidisciplinary limb salvage assessment at week 3 after endovascular revascularization of the right anterior tibial and

peroneal arteries, in the context of critical limb-threatening ischemia with dry gangrene of the right second toe and a non-healing dorsal wound. Visit purpose: reassessment of perfusion after intervention, wound and gangrene staging, evaluation for osteomyelitis of the second proximal phalanx, decision on the timing and level of digital amputation versus continued conservative salvage, and coordination of a joint podiatry-vascular surgical plan.

Wound / Ulcer History

Two lesions on the right foot. The first began in 04/2026 as a small dorsal abrasion over the second metatarsophalangeal joint, attributed to a new pair of work boots, which failed to heal and progressed to a full-thickness wound measuring 1.8 cm by 06/2026. The second is dry gangrene of the entire right second toe, which began as distal tip discoloration in 05/2026 and has advanced proximally to the level of the proximal interphalangeal joint over the last six weeks. Neither has ever shown granulation. Scant serous drainage from the dorsal wound; the gangrenous toe is dry with no drainage. Overall the limb has been deteriorating despite revascularization, with only partial symptomatic benefit.

Limb Ischemia Symptoms

Right calf claudication at approximately 40 m preceded the tissue loss and had been present for two years. Rest pain developed in 05/2026, is worst at night, and is characteristically relieved by hanging the leg over the side of the bed — he has slept in a recliner for eleven weeks. Rest pain improved substantially for the first ten days after the 07/15/2026 angioplasty and has now returned to approximately 70% of its pre-procedure severity, which is the change that prompted this urgent slot. The foot is cold and dusky when elevated. No prior acute limb ischemia event.

Neuropathy Symptoms

Dense diabetic and uremic peripheral neuropathy. He reports numbness to the mid-calf bilaterally, intermittent nocturnal burning, and a complete inability to feel the dorsal wound — it was found by his wife rather than felt by him. He has twice discovered blood on his sock without any awareness of injury. Balance is impaired and he has had two non-injurious falls in six months. Notably, the current rest pain is ischemic and breaks through the neuropathy, which is itself a marker of severity.

Infection Symptoms

No fever or chills. Increased dorsal wound pain over the last week, distinguishable to him from the ischemic rest pain. Mild surrounding erythema and warmth. Scant serous rather than purulent drainage. No foul odour. No streaking, no fluctuance, no systemic symptoms. Previous episode of cellulitis of the same foot in 02/2026 treated with 10 days of oral cephalexin. No prior osteomyelitis.

3b DIABETES, VASCULAR & OFFLOADING HISTORY

Diabetes / Metabolic History

Type 2 diabetes for 22 years. HbA1c 7.6% on 07/28/2026, historically 8–9%. Insulin glargine 22 units nightly plus insulin aspart with meals; no oral agents given ESRD. Two hypoglycemic episodes in the last month on dialysis days, both self-treated. Established triopathy — neuropathy, nephropathy now at ESRD, and proliferative retinopathy treated with panretinal photocoagulation with a visual acuity of 20/80 on the right and 20/60 on the left, which materially limits his ability to inspect his own feet.

Vascular History

Peripheral arterial disease diagnosed 2022. Right superficial femoral artery stenting 09/2024, patent on duplex. Angiography 07/15/2026 demonstrated an occluded anterior tibial artery, a severely diseased peroneal, and an occluded posterior tibial with heavy medial calcinosis throughout; balloon angioplasty of the anterior tibial and peroneal was performed with a fair angiographic result and single-vessel run-off to the foot. No bypass performed and no autologous conduit assessment to date. Contralateral left foot has palpable pulses. No prior amputation. On aspirin and rivaroxaban 2.5 mg twice daily since the 2024 stent.

Footwear / Offloading History

Custom diabetic shoes with total-contact inserts issued 2024, now visibly worn through at the forefoot and overdue for replacement. He returned to steel-toed work boots for part-time light duty in 03/2026 — the precipitant of the dorsal wound. Currently in a surgical shoe issued 06/2026. Offloading adherence is fair; he removes the surgical shoe at home and walks in socks on tile. No total contact cast — correctly avoided given the ischemia. No brace or prosthetic.

Prior Wound and Limb Treatments

Collagenase then silver alginate for the dorsal wound; currently dry gauze. Two courses of oral antibiotics in 2026. Three sharp debridements of the dorsal wound between 05/2026 and 07/2026. No debridement of the gangrenous toe — deliberately left dry. No negative pressure therapy, skin substitute, graft, or hyperbaric oxygen. Angioplasty 07/15/2026 as described. Podiatric nail and callus care every 8 weeks until 04/2026, since lapsed.

3c FUNCTION, RISK FACTORS & MEDICATIONS

Functional Impact

Ambulates household distances with a cane; community distance is now limited to under 30 m by rest pain and wound pain. Drives himself to haemodialysis three times weekly — he identifies this independence as his single most important functional goal and it shapes the amputation-level discussion. Sleeps in a recliner. Unable to wear a normal shoe on the right. Retired heavy-equipment mechanic, currently on light duty two half-days weekly. Wife assists with dressing changes and foot inspection.

Risk Factors for Limb Loss

A near-complete adverse profile: 22-year type 2 diabetes, established PAD with single-vessel run-off, dense neuropathy, ESRD on haemodialysis since 2023, active smoking at half a pack daily with a 45 pack-year history, prior cellulitis, impaired vision limiting self-inspection, protein-energy wasting with an albumin of 3.1, worn-out offloading footwear, and imperfect offloading adherence. ESRD in particular is independently associated with a markedly elevated risk of major amputation and of poor wound healing after revascularization.

Medication and Antithrombotic History

Aspirin 81 mg daily, rivaroxaban 2.5 mg twice daily (vascular dose), atorvastatin 40 mg nightly, insulin glargine and aspart, sevelamer with meals, calcitriol, epoetin alfa on dialysis, amlodipine 10 mg daily, gabapentin 300 mg nightly, and oxycodone 5 mg as needed for rest pain, currently used most nights. Adherence is good and verified with his dialysis unit. He reports the gabapentin is ineffective for the current pain. No bleeding on dual therapy.

Pertinent Negatives

No fever, rigors, or systemic illness. No rapidly spreading erythema, crepitus, bullae, or purulence to suggest necrotizing infection or wet gangrene. No sudden change in limb colour, no new motor deficit, no absent capillary return, and no uncontrolled bleeding. Denies any missed dialysis session. Denies chest pain or dyspnea.

ROS LIMB PRESERVATION REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Wound pain, drainage, odor, bleeding, swelling, redness, or necrosis	Positive — increased dorsal wound pain, mild erythema and warmth, scant serous drainage, dry gangrene of the second toe. No purulence or odour.
Claudication, rest pain, cold extremity, color change, or non-healing tissue loss	Positive — rest pain returned to ~70% of pre-procedure severity, dependency relief, cold dusky foot on elevation, two non-healing lesions.
Numbness, tingling, burning, loss of sensation, or neuropathic pain	Positive — dense numbness to mid-calf, nocturnal burning, wound undetected by the patient.
Fever, chills, fatigue, or systemic infection symptoms	Negative — afebrile, no systemic signs.
Difficulty walking, standing, transferring, wearing shoes, or using prosthetics	Positive — community ambulation under 30 m, unable to wear a normal right shoe, sleeps in a recliner.
Edema, venous disease symptoms, or skin discoloration	Mild dependent edema from recliner sleeping. Dependent rubor and elevation pallor present. No venous stasis changes.

Hyperglycemia, hypoglycemia, poor appetite, weight change, or nutrition concerns

Smoking, medication adherence, dressing supply, or offloading barriers

Positive — two hypoglycemic episodes on dialysis days, poor appetite, albumin 3.1, 4 kg loss over 6 months.

Positive — active smoking half a pack daily; worn-out diabetic footwear; surgical shoe removed at home. Medication adherence good.

o OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE

36.6 °C

HEART RATE

88 bpm

OXYGEN SATURATION

97% on room air

BMI

24.4 kg/m²

BLOOD PRESSURE

148/76 mmHg (non-fistula arm)

RESPIRATORY RATE

16 /min

WEIGHT

74.2 kg (post-dialysis dry weight 73.5 kg)

PAIN SCORE

7/10 at night with the leg elevated; 3/10 dependent

5a GENERAL, VASCULAR & PULMONARY

General Appearance

Alert, oriented, engaged, and articulate about his priorities. Mildly cachectic with temporal wasting. Ambulates with a cane and an obvious antalgic gait favouring the right forefoot. Left arm brachiocephalic arteriovenous fistula with a good thrill. Able and willing to participate in wound care with his wife.

Cardiovascular / Vascular

Right foot: dorsalis pedis and posterior tibial pulses non-palpable. Monophasic Doppler signal over the anterior tibial at the ankle, weakly biphasic at the mid-calf; posterior tibial signal absent. Capillary refill 6–7 seconds in the third and fourth toes. Foot cool from the mid-metatarsal distally with a clear temperature gradient. Dependent rubor develops within 45 seconds and pallor on elevation to 45 degrees within 20 seconds — both markedly positive. **Left foot:** dorsalis pedis and posterior tibial both palpable at 2+, warm, capillary refill under 3 seconds. Femoral and popliteal pulses palpable bilaterally. Mild dependent edema on the right. No varicosities or venous stasis change.

Pulmonary

Clear to auscultation with no crackles or wheeze. No increased work of breathing. Room air. Functionally adequate for a regional or general anaesthetic; formal anaesthetic assessment to follow surgical scheduling.

5b EXTREMITIES, NEUROLOGIC & SKIN

Extremities / Musculoskeletal

Right forefoot with prominent second metatarsal head and a mild hallux valgus. No rocker-bottom deformity, no midfoot collapse, no Charcot changes on either foot. No contracture. No prior amputation. Ankle range of motion preserved. Footwear inspected — the custom insert is compressed flat at the second metatarsal head and the surgical shoe strap is worn through. Gait antalgic with early heel rise on the right.

Neurologic

Loss of protective sensation confirmed — 10 g Semmes-Weinstein monofilament absent at 9 of 10 sites on the right and 8

of 10 on the left. Vibration absent at both halluces on 128 Hz tuning fork. Proprioception impaired at the toes bilaterally. Ankle reflexes absent. Motor strength 5/5 proximally and 4+/5 for ankle dorsiflexion bilaterally. He is entirely unable to detect injury or pressure in the forefoot.

Skin / Soft Tissue

Dry, atrophic, hairless skin over both distal legs with thickened dystrophic nails. Right second toe as described below. Dorsal wound as described below. Interdigital spaces macerated between the third and fourth toes with early tinea. Callus over the second and third metatarsal heads plantarly, without underlying ulceration on debridement inspection today. No cellulitis extending beyond 2 cm of the dorsal wound, no fluctuance, no crepitus, no lymphangitis. Left foot skin intact with callus but no wound.

WA WOUND / LIMB ASSESSMENT

6 WOUND 1 — RIGHT SECOND TOE DRY GANGRENE

WOUND NUMBER

1 of 2

LOCATION AND LATERALITY

Right second toe, distal tip to the proximal interphalangeal joint

WOUND TYPE OR SUSPECTED ETIOLOGY

Ischemic dry gangrene secondary to critical limb-threatening ischemia

DATE FIRST ASSESSED

05/2026 (tip discolouration); by this service 06/09/2026

DIMENSIONS

Full circumferential mummification of the distal 2.6 cm of the toe; demarcation line now at the PIP joint

WOUND CLASSIFICATION OR GRADE

WIFI: Wound 2, Ischemia 3, foot Infection 0 for this lesion

EXUDATE

None — dry, mummified, no drainage

WOUND PHOTOGRAPHS OBTAINED

Yes — 4 images with scale, filed to the chart

Wound bed, edges and demarcation

Black, dry, mummified tissue with a firm leathery texture. A clear demarcation line has formed at the level of the proximal interphalangeal joint, sharper and more proximal than at the 07/08 assessment when it sat at the distal interphalangeal joint. The proximal toe skin is dusky but not frankly necrotic. No exposed bone visible, no tunneling, no undermining.

Signs of infection, ischemia, gangrene, abscess, or deep tissue involvement

Pure dry gangrene — no wet component, no purulence, no odour, no fluctuance, no crepitus, no surrounding cellulitis. Ischemia is severe and is the sole driver. No abscess. No evidence of ascending infection.

Comparison to prior assessment

Progressed. The demarcation has advanced proximally from the DIP to the PIP joint over four weeks despite revascularization, indicating the angioplasty result has not delivered sufficient perfusion to arrest the process.

6b WOUND 2 — RIGHT DORSAL SECOND MTP JOINT WOUND

WOUND NUMBER

2 of 2

LOCATION AND LATERALITY

Right dorsum, overlying the second metatarsophalangeal joint

WOUND TYPE OR SUSPECTED ETIOLOGY

Neuroischemic wound from footwear trauma, non-healing on the basis of ischemia

DATE FIRST ASSESSED

04/2026; by this service 06/09/2026

DIMENSIONS

WOUND CLASSIFICATION OR GRADE

2.1 cm × 1.6 cm × 0.9 cm (from 1.8 × 1.4 × 0.6 cm on 07/08)

EXUDATE

Scant serous, non-purulent, no odour

Undermining, wound bed and edges

Undermining of 0.6 cm from 11 o'clock to 2 o'clock. Wound bed approximately 60% pale non-proliferative granulation, 30% adherent yellow slough, and 10% fibrinous exudate. **Probe-to-bone equivocal** — a firm resistance is felt at the depth of the second metatarsal head but bone is not clearly visualised. Edges are non-advancing, thin, and macerated inferiorly. No exposed tendon, joint capsule, or hardware.

Periwound condition, bleeding, friability

Erythema extending 1.5–2 cm circumferentially, warm but blanching, without induration or fluctuance. Granulation is pale and bleeds only sluggishly on debridement — a poor perfusion sign. Maceration inferiorly. No hemosiderin staining.

Signs of infection, ischemia, gangrene, abscess, or deep tissue involvement

Mild superficial infection is present — increased pain, erythema, and warmth without purulence or systemic features, corresponding to IDSA mild and Wifl foot Infection grade 1. Ischemia is the dominant obstacle. Osteomyelitis of the second metatarsal head or proximal phalanx cannot be excluded and requires imaging.

Pain and comparison to prior measurement

Palpation of the wound elicits 5 of 10 pain, up from 2 of 10 in July — a change consistent with early infection rather than with the neuropathy. Dimensions have increased on all three axes over four weeks. This wound is deteriorating.

Wifl: Wound 2, Ischemia 3, foot Infection 1 — combined clinical stage 4

WOUND PHOTOGRAPHS OBTAINED

Yes — 3 images with scale, filed to the chart

CL LIMB THREAT / CLASSIFICATION

7 LIMB PRESERVATION RISK CLASSIFICATION

DIABETIC FOOT ULCER GRADE / CLASSIFICATION

Neuroischemic diabetic foot ulcer with tissue loss and gangrene

WAGNER GRADE

Grade 4 — localized gangrene of the forefoot

PRESSURE INJURY STAGE

Not applicable

GANGRENE EXTENT AND LOCATION

Dry gangrene, right second toe, demarcated at the proximal interphalangeal joint

PRIOR AMPUTATION LEVEL AND STUMP STATUS

None — no prior amputation on either limb

Osteomyelitis concern

WIFI CLASSIFICATION

W2 I3 f11 — clinical stage 4; high amputation risk, high benefit from revascularization

UNIVERSITY OF TEXAS CLASSIFICATION

Grade II, Stage D — wound to tendon or capsule with both infection and ischemia

CRITICAL LIMB-THREATENING ISCHEMIA STATUS

Present and persistent — rest pain plus tissue loss, with only partial and non-durable haemodynamic benefit from angioplasty

CHARCOT STAGE OR DEFORMITY STATUS

No Charcot arthropathy; second metatarsal head prominence and mild hallux valgus only

OVERALL AMPUTATION RISK

High for minor amputation, which is now near-certain; moderate for major amputation if perfusion is not further improved

Moderate to high for the second metatarsal head or proximal phalanx. Wound depth 0.9 cm with equivocal probe-to-bone over a bony prominence, a wound present for four months, and rising inflammatory markers. MRI is required — plain films are insufficient at this stage and a negative radiograph would not exclude it.

Abscess or deep space infection concern

Low. No fluctuance, no purulence, no crepitus, no dorsal compartment tension, and no systemic features. The infection is superficial and mild. MRI will nonetheless exclude a deep collection.

PR PROCEDURES PERFORMED

8 LIMB PRESERVATION PROCEDURES THIS VISIT

PROCEDURE NAME

Selective sharp debridement of the dorsal wound with deep tissue culture; bedside non-invasive perfusion testing

INDICATION

Non-viable slough limiting assessment; suspected infection requiring organism identification; perfusion reassessment after angioplasty

WOUND OR LIMB LOCATION AND LATERALITY

Right dorsal foot, second metatarsophalangeal joint

CONSENT OBTAINED

Verbal consent obtained and documented

ANESTHESIA, IF USED

None required — dense loss of protective sensation; patient declined local

INSTRUMENTS USED

Sterile curette, Adson forceps, #15 blade

TISSUE REMOVED

Adherent yellow slough and non-viable fibrinous tissue, approximately 1.2 cm² superficially only

BLEEDING / HEMOSTASIS

Minimal, sluggish capillary ooze; hemostasis with 2 minutes of light pressure

POST-PROCEDURE MEASUREMENTS

2.1 cm × 1.6 cm × 1.0 cm after slough removal

DRESSING AND OFFLOADING APPLIED

Non-adherent contact layer with dry gauze and a light wrap; surgical shoe refitted with a new strap

Technique

Deliberately conservative debridement. Only clearly non-viable superficial slough was removed sharply from the dorsal wound. Aggressive debridement was expressly avoided given ischemia grade 3 — debriding into marginally perfused tissue in an unrevascularized foot converts a stable wound into a larger one. Deep tissue culture was taken by the Levine technique from the debrided base after saline cleansing. The bone was probed but no bone biopsy was attempted at the bedside. **The gangrenous second toe was not debrided or manipulated in any way** — dry, demarcated gangrene must be kept dry and allowed to auto-amputate or be resected surgically, never debrided in clinic. Interdigital tinea treated with topical antifungal. Plantar callus pared to inspect for occult ulceration; none found.

Patient tolerance and complications

Tolerated without difficulty; no pain during debridement given the sensory loss. No bleeding complication despite aspirin and rivaroxaban. No vasovagal event. No complications.

L LABORATORY AND DIAGNOSTIC RESULTS

9 RESULTS REVIEWED OR ORDERED

Laboratory Studies — 08/03/2026 (pre-dialysis draw)

White cells 11.2 K/ μ L with 78% neutrophils (from 8.4 on 07/08). Hemoglobin 10.4 g/dL on epoetin. Platelets 288. ESR 74 mm/hr, CRP 48 mg/L (from 19 on 07/08) — both rising. HbA1c 7.6%. Glucose 168 mg/dL. Albumin 3.1 g/dL, prealbumin 18 mg/dL. Pre-dialysis creatinine 7.8 with a BUN of 62; potassium 4.9, phosphate 5.4, corrected calcium 9.1, PTH 386. INR 1.2.

Microbiology

Deep tissue culture obtained today from the dorsal wound, pending. A superficial swab on 07/08 grew mixed flora with methicillin-sensitive *Staphylococcus aureus* and was not treated as it was clinically quiescent at the time. No history of MRSA, VRE, or ESBL colonisation. Blood cultures not indicated — afebrile with no systemic features.

Imaging

Right foot radiograph 07/08/2026: extensive medial arterial calcification, soft tissue gas absent, no definite cortical destruction at the second metatarsal head, dystrophic soft tissue changes distal to the second PIP joint. **MRI of the right forefoot without contrast ordered urgently today** for osteomyelitis assessment — non-contrast because of ESRD and gadolinium risk. Bone scan and tagged white cell scan are not preferred in this setting given their poor specificity in a neuroischemic foot.

Vascular Studies

ABI is uninterpretable at 1.34 on the right owing to medial calcinosis — explicitly not reassuring and not to be relied upon. **Toe pressure 22 mmHg with a toe-brachial index of 0.16**, measured today (26 mmHg on 07/22, one week post-angioplasty). **TcPO₂ on the dorsum 21 mmHg** (28 mmHg on 07/22) — both below the 30 mmHg threshold generally required for forefoot healing and both trending down. Arterial duplex today: SFA stent patent with a peak systolic velocity ratio of 1.4; anterior tibial with a monophasic, dampened waveform and evidence of restenosis at the angioplasty site; peroneal monophasic; posterior tibial occluded. Left ABI 1.1 with triphasic pedal waveforms.

Pathology

No tissue pathology to date. Bone biopsy or intraoperative bone specimen recommended at the time of surgery to establish the diagnosis of osteomyelitis and to direct antibiotic therapy and the resection margin.

Prior Records Reviewed

Vascular surgery consultation and the 07/15/2026 angiography and angioplasty report with run-off images, SFA stent records from 09/2024, all limb preservation clinic notes and wound photographs from 06/09 to 07/22, nephrology and haemodialysis unit records including the dialysis prescription and interdialytic weights, ophthalmology records confirming visual acuity, and the medication administration record from the dialysis unit. Approximately 22 minutes of independent record review, plus a joint 15-minute case discussion with Dr. Brasfield during this session.

A

ASSESSMENT

10 LIMB PRESERVATION CLINICAL INTERPRETATION

- **Critical limb-threatening ischemia of the right lower limb with dry gangrene of the second toe and a deteriorating neuroischemic dorsal wound — WifI clinical stage 4.** This is a high-risk limb with a high anticipated benefit from further revascularization.
- **The 07/15 angioplasty has failed to deliver durable perfusion.** Toe pressure has fallen from 26 to 22 mmHg and TcPO₂ from 28 to 21 mmHg over two weeks, rest pain has returned to roughly 70% of its pre-procedure severity, duplex shows restenosis at the anterior tibial angioplasty site, and the gangrene demarcation has advanced proximally. Every objective and subjective measure points the same way.
- **Perfusion is below the healing threshold.** A toe pressure of 22 mmHg and a dorsal TcPO₂ of 21 mmHg are both well under the 30 mmHg generally required for forefoot wound healing or for a digital amputation to heal. **Amputating at any level in this foot today would very likely fail.** This is the single most important conclusion of the visit.

- **The ABI of 1.34 is falsely elevated by medial calcinosis** and must not be used to reassure anyone about this limb. Toe pressure and TcPO₂ are the valid measures here, and both are unequivocal.
- **Mild superficial infection of the dorsal wound with probable underlying osteomyelitis.** Rising white cells, ESR 74, CRP 48, wound depth 0.9 cm over a bony prominence with equivocal probe-to-bone, and increased pain against a background of dense neuropathy. MRI is required. There is no evidence of wet gangrene, abscess, deep space infection, or systemic sepsis — this is not an emergency today.
- **The gangrene is dry and stable and should stay that way.** No debridement, no soaking, no occlusive dressing. Conversion of dry to wet gangrene in an ischemic foot is the event that turns a planned minor amputation into an urgent major one.
- **Healing barriers beyond perfusion are substantial:** ESRD on haemodialysis (independently the strongest non-vascular predictor of major amputation in this population), active smoking, protein-energy wasting with an albumin of 3.1, impaired vision preventing self-inspection, worn-out offloading footwear, and imperfect offloading adherence.
- **Limb salvage potential remains genuine but is conditional.** The pathway is: re-establish perfusion first, then stage the minor amputation. If repeat revascularization fails and TcPO₂ cannot be brought above 30 mmHg, a below-knee amputation becomes the realistic option, and he should hear that framed honestly and early rather than late.
- **His stated goal — continuing to drive himself to dialysis — is clinically relevant and achievable** with a transmetatarsal or digital amputation, and remains achievable with a well-fitted below-knee prosthesis. This goal should anchor the shared decision-making rather than sit outside it.
- **The contralateral left foot is at high risk and currently intact** — loss of protective sensation at 8 of 10 sites with palpable pulses and callus. Protecting it is a parallel priority, not an afterthought.

P

PLAN

11 LIMB PRESERVATION MANAGEMENT BY PROBLEM

- **Repeat revascularization — the controlling priority.** Discussed jointly with Dr. Brasfield during this session. Repeat angiography with a view to re-intervention on the anterior tibial restenosis, and formal assessment for a distal bypass with vein mapping of the great saphenous vein bilaterally. Scheduled for 08/11/2026. **No amputation to be performed before perfusion is reassessed** — this is recorded explicitly to prevent a well-intentioned but doomed digital amputation in the interim.
- **Perfusion reassessment:** repeat toe pressure and TcPO₂ at 1 week after any re-intervention, with a healing threshold of TcPO₂ above 30 mmHg documented as the gate for surgery. Vein mapping ordered today. ABI is to be disregarded in this patient and this is flagged in the chart.
- **Osteomyelitis workup:** non-contrast MRI of the right forefoot urgently, gadolinium avoided given ESRD. Deep tissue culture already sent. Bone biopsy or an intraoperative bone specimen at the time of surgery to confirm the diagnosis and set the resection margin. A prolonged antibiotic course will not be committed to before a bone specimen is available.
- **Infection management:** empiric oral doxycycline 100 mg twice daily started today for mild soft tissue infection with prior MSSA, chosen for reliable staphylococcal cover with no renal dose adjustment required in ESRD. To be narrowed or stopped on culture. Infectious disease consultation requested for the osteomyelitis pathway and for dialysis-compatible dosing. Escalation criteria given in writing: fever, spreading erythema, purulence, odour, or any change from dry to moist gangrene warrants same-day contact.
- **Gangrenous toe — strict dry management:** keep dry and open to air, paint with povidone-iodine daily and allow to dry, no soaking, no occlusive or moist dressing, no debridement. Daily inspection by his wife for moisture, drainage, odour, or proximal erythema with same-day reporting.

- **Dorsal wound care:** non-adherent contact layer with dry gauze changed daily, deliberately avoiding moisture-donating dressings in an ischemic foot. Conservative sharp debridement only, at clinic visits, limited to clearly non-viable tissue. **Negative pressure wound therapy, skin substitutes, and hyperbaric oxygen are all deferred** — none is appropriate or effective at a TcPO₂ of 21 mmHg. Hyperbaric therapy may be reconsidered only after successful revascularization.
- **Offloading:** surgical shoe refitted today with a new strap and heel counter, to be worn for all weight-bearing including indoors — he was walking in socks on tile and this was addressed directly. **Total contact casting is contraindicated** given ischemia grade 3 and is documented as such. New custom diabetic shoes with total-contact inserts ordered today for both feet; the current pair is worn through. Weight-bearing minimized pending surgery.
- **Smoking cessation:** the single most important thing he can personally do to keep the leg. Framed in exactly those terms. Nicotine replacement started with a 14 mg patch daily plus 2 mg lozenges, tobacco treatment service referral placed with an expedited appointment requested, and cessation progress to be reviewed at every visit.
- **Diabetes and nutrition:** glycemic target relaxed to 140–180 mg/dL to avoid dialysis-day hypoglycemia; insulin regimen review requested from the dialysis unit and endocrinology. Renal dietitian referral for protein-energy wasting with a target of 1.2 g/kg of protein on non-dialysis days and higher on dialysis days, with intradialytic parenteral nutrition considered if the albumin does not improve. Prealbumin to be rechecked in 3 weeks.
- **Pain management:** ischemic rest pain is inadequately controlled. Increase gabapentin to 300 mg after each dialysis session only (renally dosed) and continue oxycodone 5 mg at night. Definitive pain relief depends on revascularization, and he was told so plainly. Palliative care co-referral offered for pain support and declined for now.
- **Contralateral limb protection:** left foot at high risk with loss of protective sensation and callus. Preventive podiatric care reinstated at 8-week intervals for both feet, callus paring, custom insert included in the footwear order, and daily inspection by his wife given his visual impairment.
- **Multidisciplinary coordination:** joint podiatry-vascular assessment completed this session. Note routed to Dr. Brasfield (vascular surgery), Dr. Fitzgerald (primary care), nephrology and the haemodialysis unit, infectious disease, endocrinology, the renal dietitian, and orthotics. Dialysis unit specifically asked to inspect and document the right foot at every session and to report any change.
- **Shared decision-making and patient education:** 28 minutes spent reviewing the perfusion data in plain terms, why amputation cannot precede revascularization, the realistic range of outcomes from digital amputation through transmetatarsal to below-knee, and the effect of smoking on each. His goal of continuing to drive himself to dialysis was documented and used to frame the amputation-level discussion. Written escalation criteria and a wound-care instruction sheet provided to him and to his wife.

F

FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up timeframe and purpose

Vascular surgery with repeat angiography and possible re-intervention on 08/11/2026. Limb preservation clinic in 7 days (08/12) for wound remeasurement, culture and MRI review, antibiotic narrowing, and repeat toe pressure and TcPO₂ after any re-intervention, then weekly while the limb remains threatened. Vein mapping before 08/11. Infectious disease within 1 week. Renal dietitian within 2 weeks; prealbumin at 3 weeks. Tobacco treatment service within 2 weeks. Dialysis unit to inspect the foot three times weekly. **Same-day contact or emergency presentation** instructed for fever, spreading redness, purulence, foul odour, the gangrene becoming moist or draining, sudden increase in pain, or any change in foot colour.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

85 minutes

PROCEDURE TIME

18 minutes — selective debridement with deep tissue culture

COUNSELING / COORDINATION OF CARE TIME

28 minutes — shared decision-making, smoking cessation, escalation criteria

RECORDS REVIEW TIME

22 minutes

MULTIDISCIPLINARY CARE COORDINATION TIME

15 minutes — joint case discussion with vascular surgery

HOME HEALTH / SUPPLY COORDINATION TIME

8 minutes — footwear order, dialysis unit instructions

BASIS FOR BILLING

Procedure-based plus Medical Decision Making (high complexity), separately identifiable E/M

E/M LEVEL

99215 with modifier 25 — established patient, high MDM

DEBRIDEMENT CODE(S)

97597 — selective debridement, open wound, first 20 sq cm or less

WOUND PROCEDURE CODE(S)

87070 — culture, bacterial, deep tissue

VASCULAR / PERFUSION TESTING CODE(S)

93923 — complete bilateral non-invasive physiologic study with toe pressures

SKIN SUBSTITUTE / GRAFT CODE(S)

Not applicable — deferred pending revascularization

NEGATIVE PRESSURE WOUND THERAPY CODE(S)

Not applicable — contraindicated at current perfusion

COMPRESSION / CAST / OFFLOADING CODE(S)

A5500 — diabetic shoes with custom inserts (bilateral, ordered)

PRIMARY ICD-10 DIAGNOSIS CODE

I70.263 — Atherosclerosis of native arteries of extremities with gangrene, bilateral legs

SECONDARY ICD-10 DIAGNOSIS CODE(S)

E11.621 — Type 2 diabetes with foot ulcer; L97.512 — Non-pressure chronic ulcer of other part of right foot with fat layer exposed; E11.51 — Type 2 diabetes with diabetic peripheral angiopathy without gangrene; E11.42 — Type 2 diabetes with diabetic polyneuropathy; N18.6 — End stage renal disease; Z99.2 — Dependence on renal dialysis; M86.671 — Other chronic osteomyelitis, right ankle and foot (suspected); F17.210 — Nicotine dependence, cigarettes; E44.0 — Moderate protein-calorie malnutrition; E11.359 — Type 2 diabetes with proliferative retinopathy; Z98.62 — Peripheral vascular angioplasty status

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Katherine Marsh, DPM

CREDENTIALS

DPM, FACFAS

SPECIALTY

Limb Preservation /
Podiatric Surgery

DATE

08/05/2026

TIME

3:24 PM