Managing Common Infections

Diabetic Foot Infection: antimicrobial prescribing

Stakeholder comments table

16/04/2019 – 16/05/2019

ID	ORGANISATION NAME	DOCUMENT	PAGE NO.	LINE NO.	COMMENTS	DEVELOPER'S RESPONSE
1	Ipswich Hospital, ESNEFT	Guideline	15	4 (Table 1)	Dose of flucloxacillin should be 1g QDS	Thank you for your comment. The committee discussed your comment and has changed the dosing of flucloxacillin to a range from 500 mg to 1 g for mild diabetic foot infection, and 1 g orally or 1 to 2 g IV for moderate or severe diabetic foot infection
2	Ipswich Hospital, ESNEFT	Guideline	15	4 (Table 1)	Dose of Doxycylcine –I'd suggest 200mg /day	Thank you for your comment. The committee discussed your comment and has added that the daily dose can be increased from 100 mg to 200 mg after the initial dose of 200 mg on the first day of treatment with doxycycline for mild diabetic foot infection.
3	Ipswich Hospital, ESNEFT	Guideline	15	4 (Table 1)	Any other alternative to co trimoxazole for pen allergic ? as high chance of side effects ?role for clindamycin	Thank you for your comment. The committee discussed the use of co-trimoxazole and a footnote has been added to outline the need to follow relevant professional guidance, taking full responsibility for the decision and obtaining informed consent when making the decision to prescribe co-trimoxazole for the treatment of moderate or severe diabetic foot infections. The committee discussed the use of clindamycin and it has now been added to the prescribing table as an option for the treatment of moderate or severe infection if pseudomonas aeruginosa is suspected or confirmed.

4	Ipswich Hospital, ESNEFT	Guideline	15	4 (Table 1)	Ceftriaxone and metronidazole will not cover pseudomonas and this can be a relevant pathogen	Thank you for your comment. The committee discussed your comment and the prescribing table has been amended to indicate that ceftriaxone and metronidazole is an option in moderate or severe diabetic foot infection. A separate section on antibiotic choices in people who have suspected or confirmed Pseudomonas aeruginosa has been added, with choices including piperacillin with tazobactam or clindamycin with ciprofloxacin and/or gentamicin. The committee were satisfied that this provides antibiotic options with suitable coverage of pseudomonas.
5	Ipswich Hospital, ESNEFT	Guideline	14	1	Not many options for pen allergic in severe infections	Thank you for your comment. The committee discussed your comment regarding the antibiotic choices for penicillin allergic individuals with severe infection. They agreed that co-trimoxazole represents an adequate antibiotic choice for this group but acknowledged the concerns regarding its use. A footnote has been added to outline the need to follow relevant professional guidance, taking full responsibility for the decision and obtaining informed consent when making the decision to prescribe co-trimoxazole for the treatment of moderate or severe diabetic foot infections.
6	Quality and leadership, NICE	General			The quality standard on diabetes in adults (QS6) uses NG19 as source guidance for quality statements 5 and 6 which relate to referral for diabetic foot problems. These quality statements are based on recommendations 1.3.8 and 1.4.1, and use recommendations 1.2.1 – 1.2.4 in definitions, which are not affected by the changes to the guideline.	Thank you for your comment.
7	Quality and leadership, NICE	General			The proposed changes to the recommendations will not impact on QS6.	Thank you for your comment.
8	Royal College of Paediatrics and Child Health	General	General	General	The reviewer was happy with the guideline	Thank you and we welcome the Royal College of Paediatrics and Child Health's statement.

9	Royal Pharmaceutical Society	Draft guideline	14	7	Why should antibiotics should start as soon as possible? If the patient is well and otherwise stable, the priority is to obtain a good quality sample to allow targeted antibiotic therapy.	Thank you for your comment. The rationale underpinning the recommendation is outlined in the guideline. The committee discussed your comment and has agreed that due to the potential for serious complications, antibiotics should be started as soon as possible if a diabetic foot infection is suspected. NO change has been made to this recommendation.
10	Royal Pharmaceutical Society	Draft guideline	14	9	To support AMS there should be mention of rationalisation/ narrowing spectrum following microbiology results	Thank you for your comment. The guideline outlines that when microbiological results are available antibiotics should be changed according to the result, using a narrow spectrum antibiotic if appropriate.
11	Royal Pharmaceutical Society	Draft guideline	15	4	We suggest preferential use of oral metronidazole given its good oral bioavailability	Thank you for your comment. Oral metronidazole 400 mg three times a day is an option (in combination with ceftriaxone, flucloxacillin or co-trimoxazole with or without gentamicin) in the treatment of moderate or severe diabetic foot infection. Recommendation 1.6.10 states that when choosing an antibiotic give oral antibiotics first line if the person can take oral medication and if the severity of their condition does not require intravenous antibiotics. The guideline also states that if intravenous antibiotics are given, review by 48 hours and consider switching to oral antibiotics if possible.
12	Royal Pharmaceutical Society	Draft guideline	16	Table	Cautions around linezolid use as in diabetic foot infection course lengths may be long and there are many interactions/ contraindications plus monitoring requirements due to toxicity	Thank you for your comment. Currently linezolid is only an option if vancomycin cannot be used and/or based on specialist advice. The committee have considered the point you raised regarding interactions, contraindications and potential toxicity but agreed that linezolid is an appropriate antibiotic choice for diabetic foot infection. A footnote has been added which links to the BNF and provides more information on monitoring of patient parameters.
13	Diabetes UK	Guideline	4-5	General	We note that the draft guideline recommends referring an individual to a multidisciplinary foot care service (MDFCS)	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15)

					within 24 hours of being hospitalised (1.1.3). However, as the National Diabetes Foot Care Audit highlights (https://files.digital.nhs.uk/73/39E604/ndfa-3ar-rep-1.pdf), MDFCSs are not in place in all hospitals. While the draft guideline does say "commissioners and service providers should ensure… a multidisciplinary foot care service" is in place, we suggest that the guideline should make the language here stronger. The guideline should state that a MDFCS is a necessity for providing adequate care for people with diabetic foot problems and that commissioners and service providers must ensure that a MDFCS is in place to provide adequate care.	which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations (including 1.1.3) as we have not reviewed the evidence regarding these.
14	Diabetes UK	Guideline	10	20-25	In section 1.4.1 where limb-threatening conditions are listed, Charcot Foot should be included in the list. Evidence demonstrates that Charcot Foot is limb-threatening and individuals with Charcot Foot should be offered the same care as those with the other limb-threatening conditions listed. http://care.diabetesjournals.org/content/34/9/2123	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations (for example 1.4.1) as we have not reviewed the evidence regarding these.
15	Diabetes UK	Guideline	12	23-27	Section 1.5.10 should reference MGT42 on using UrgoStart for treating diabetic foot ulcers and leg ulcers. This would bring the guideline in line with other NICE guidance. https://www.nice.org.uk/guidance/mtg42	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations (for example 1.5.10) as we have not reviewed the evidence regarding these.

16	Diabetes UK	Guideline	18	10-14	As discussed above, Charcot Foot is a limb-threatening condition. We suggest that a diagnosis of Charcot Foot, if suspected, should be treated as a priority and waiting for 1 or 2 working days before confirmation would be dangerous and could undermine treatment.	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations (for example 1.7 Charcot arthropathy) as we have not reviewed the evidence regarding these.
17	British Infection Association	Draft guideline	15	Table 1	We are concerned about the excessive use of gentamicin for moderate or severe diabetic foot infection. These patients usually have pre-existing diabetic nephropathy and are susceptible to further insults with nephrotoxic drugs and vestibular toxicity could be life-changing in these patients. Gentamicin monitoring is not always reliably performed. The implication from this table is that gentamicin should be given for 7 days and possibly up to 6 weeks. A prolonged course of aminoglycoside would lead to significant clinical risk. In these patients caution should be taken with prescribing gentamicin and in most cases a maximum of 48 hours before switching to another agent.	Thank you for your comment. The use of gentamicin is outlined as an optional antibiotic choice for moderate or severe diabetic foot infection to be used with flucloxacillin, co-amoxiclav or with co-trimoxazole (in penicillin allergies) or with clindamycin and ciprofloxacin if pseudomonas aeruginosa is suspected or confirmed. The committee decided to keep gentamicin as a treatment option in moderate or severe diabetic foot infection, because it is a valid option for treatment, taking into account clinical assessment and microbiological results when available. A footnote has been added to the prescribing table which links to the BNF, providing more information on therapeutic drug monitoring and the monitoring of patient parameters.
18	British Infection Association	Draft guideline	15	Table 1	Co-trimoxazole should have a note by it about monitoring FBC in view of the risk of bone marrow suppression when it is used.	Thank you for your comment. The committee discussed your comment and a footnote has been added to the prescribing table referring to the BNF and information regarding monitoring of patient parameters.
19	British Infection Association	Draft guideline Draft guideline	15	Table 1	Clindamycin is often used by our members rather than macrolides.	Thank you for your comment. The committee discussed the use of clindamycin and it has been added to the prescribing table as a choice for moderate or severe diabetic foot infection if Pseudomonas aeruginosa is suspected or confirmed.

20	British Infection Association	Draft guideline	15	Table 1	Teicoplanin may be used rather than vancomycin if dosing is appropriate to bone infection (e.g. supporting evidence Svetitsky et al. 2009 PMID: 19596875).	Thank you for your comment. The committee discussed the use of teicoplanin, and it has been added to the prescribing table as an antibiotic choice for moderate or severe infection if MRSA infection is suspected or confirmed.
21	British Infection Association	Draft guideline	15	Table 1	A smaller number of our members are concerned that the choice of ceftriaxone and metronidazole in the severe cases would not cover *Pseudomonas* and in such cases consideration should be given to regimes which would be effective against this pathogen (e.g. ceftazidime + teicoplanin + metronidazole).	Thank you for your comment. The committee discussed your comment and the prescribing table has been amended to say that ceftriaxone with metronidazole is an option in moderate or severe diabetic foot infection (where Pseudomonas aeruginosa is not suspected or confirmed). Alternative antibiotic choices for moderate or severe infection where Pseudomonas aeruginosa is suspected or confirmed include piperacillin with tazobactam, clindamycin with ciprofloxacin and/or gentamicin, with antibiotic choice guided by microbiological results when available. The committee were satisfied that the options listed provide suitable coverage of Pseudomonas aeruginosa.
22	British Infection Association	Evidence review	28	3.1.12 Antibiotic route of administr ation in adults	This states “No systematic reviews or randomised controlled trials met the inclusion criteria”. The review should consider; Li et al Oral versus Intravenous Antibiotics for Bone and Joint Infection. N Engl J Med. 2019 Jan 31;380(5):425-436	Thank you for your comment and the Li et al (2019) reference. This study was published outside of the search dates for this guideline, and therefore it was not included in the evidence review. When the guideline is considered for update, searches will be re-run and any additional references that match the review protocol will be considered and a decision will be made on whether the guideline requires an update or not.
23	British Infection Association	Draft guideline and 2015 documents: Diabetic foot problems: prevention and management	gener al		There is no guidance on the clinical criteria for conservative (antimicrobials) or surgical management of the acute diabetic foot infection. E.g. Urgent surgery required if: • Systemic toxicity with associated soft tissue infection. • Necrotising fasciitis, gas in the deeper tissues, abscess, Less urgent but requires consideration if:	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. The evidence for surgical procedures for diabetic foot infections and the clinical criteria to inform decision making regarding antimicrobial or surgical management

					• substantial cortical destruction, extensive bone or joint involvement, macroscopic bone fragmentation (sequestra), or necrotic on X-ray. • Visible, chronically exposed bone or tendon. • An open or infected joint space	of acute diabetic foot infection were not considered by the committee.
24	British Infection Association	Draft guideline and 2015 documents: Diabetic foot problems: prevention and management	General		Consider previous antibiotic therapy in the stratification of patients with diabetic foot infection.	Thank you for your comment. The guideline refers to the need to account for previous antibiotic use when choosing an antibiotic for people with a suspected diabetic foot infection.
25	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review		General	Consideration of OPAT for the treatment of osteomyelitis where there are no oral options.	Thank you for your comment. The committee discussed your comments and antibiotic choices which are suitable for outpatient parenteral antimicrobial therapy (OPAT) have been added to the prescribing table.
26	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review	Table 4 – page 15	General	Gentamicin should be limited to 48 hours as we ordinarily do not use for longer than 48 hours due to poor penetration into tissue particularly in DFI with poor vasculature.	Thank you for your comment. No change has been made to the prescribing table. The use of gentamicin is outlined as an optional antibiotic choice for moderate or severe diabetic foot infection to be used with flucloxacillin, co-amoxiclav or with co-trimoxazole (in penicillin allergy) or with clindamycin and ciprofloxacin if pseudomonas aeruginosa is suspected or confirmed. The guideline also recommends that intravenous (IV) therapy is reviewed by 48 hours and switched to oral antibiotics where possible.
27	UK Clinical Pharmacy Association (UKCPA)	Guideline review		General	Empiric therapy directed at *P. aeruginosa* is usually unnecessary except for patients with risk factors for true infection with this	Thank you for your comment. The committee discussed your comment and the prescribing table has been amended to clarify antibiotic choices for moderate or severe diabetic foot

	Pharmacy Infection Network				organism. I think this needs to be made clear within the guideline.	infections (where Pseudomonas is not suspected or confirmed) and for moderate or severe infection where Pseudomonas is suspected or confirmed. Diabetic foot infection is a serious condition and if suspected requires antibiotic treatment. The recommendations outline that microbiological testing be undertaken beforehand which provide the prescriber with the option to make subsequent clinical decision regarding treatment.
28	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review	Table 4 – page 15	General	Cautions around linezolid use as in DFI course lengths may be long and many interactions/ contraindications plus monitoring requirements due to toxicity.	Thank you for your comment. Currently linezolid is only an option if vancomycin cannot be used and/or based on specialist advice. The committee have considered the point you raised regarding interactions, contraindications and potential toxicity but agreed that linezolid is an appropriate antibiotic choice for diabetic foot infection. A footnote has been added which links to the BNF where more information is provided on monitoring of patient parameters.
29	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review	Table 4 – page 15	General	Suggest preferential use of oral metronidazole given its good oral bio-availability.	Thank you for your comment. Oral metronidazole 400 mg three times a day is an option (in combination with ceftriaxone, flucloxacillin or co-trimoxazole with or without gentamicin) in the treatment of moderate or severe diabetic foot infection. Recommendation 1.6.10 states that when choosing an antibiotic give oral antibiotics first line if the person can take oral medication and if the severity of their condition does not require intravenous antibiotics. The guideline also states that if intravenous antibiotics are given, review by 48 hours and consider switching to oral antibiotics if possible.
30	UK Clinical Pharmacy Association (UKCPA) Pharmacy	Guideline review	Table 4 – page 15	General	‘960 mg twice a day orally or 960 mg twice a day (increased to 1.44 g twice a day in severe infection) IV’ To move the IV to the top line so it reads better.	Thank you for your comment. The antibiotic prescribing table has been amended in response to stakeholder comments. Oral doses are in one column and the IV dose is in a separate column

	Infection Network					
31	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review		General	For mild MRSA colonised DFI to consider doxycycline or co-trimoxazole as treatment.	Thank you for your comment. Currently the antibiotic choice for suspected or confirmed MRSA, is the addition of IV vancomycin or teicoplanin or oral or IV linezolid (if vancomycin or teicoplanin cannot be used and on specialist use only) to current antibiotic choice depending on the severity of the diabetic foot infection. The committee considered this to be adequate.
32	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review		General	Empiric coverage for *Pseudomonas aeruginosa* may not be necessary except in severe cases or when the patient has particular risk for involvement with this organism, such as a macerated wound or one with significant water exposure. Treatment option of Ceftriaxone + metronidazole offers no pseudomonal cover. This should be made clear on the guidance.	Thank you for your comment. The committee discussed your comment and the prescribing table has been amended to indicate that ceftriaxone and metronidazole is an option in moderate or severe diabetic foot infection. A separate section on antibiotic choices in people who have suspected or confirmed Pseudomonas aeruginosa has been added, with choices including piperacillin with tazobactam or clindamycin with ciprofloxacin and/or gentamicin. The committee were satisfied that this provides antibiotic options with suitable coverage of pseudomonas.
33	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review	Table 4 – page 15	General	In moderate infection (penicillin allergy) should clindamycin be considered as an option since co-trimoxazole will not be suitable in many patients.	Thank you for your comment. Alternative options in moderate or severe infection include flucloxacillin with or without gentamicin and/ or metronidazole, co-amoxiclav with or without gentamicin and ceftriaxone with metronidazole. The committee discussed the use of clindamycin and it has been added to the prescribing table as an option for moderate or severe infection only if Pseudomonas aeruginosa is suspected or confirmed.
34	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review	Table 4 – page 16	General	Linezolid should include some further information re route – at present suggest IV but has good bioavailability.	Thank you for your comment. The committee discussed your comment and have added linezolid as an oral option in addition to IV.

35	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review	Table 4 – page 16	General	Some Trusts may prefer teicoplanin to vancomycin as this facilitates ambulation via OPAT.	Thank you for your comment. The committee discussed your comment and teicoplanin has been added to the prescribing table as an antibiotic choice to be added if MRSA infection is suspected or confirmed in combination with therapy prescribed for mild, moderate or severe diabetic foot infection.
36	UK Clinical Pharmacy Association (UKCPA) Pharmacy Infection Network	Guideline review	Table 4 – page 15/16	General	For gentamicin & vancomycin – consider adding 'adjust according to serum concentrations and local guidelines'.	Thank you for your comments. A footnote has been added which links to the BNF which provides more information on therapeutic drug monitoring and the monitoring of patient parameters.
37	Salford Royal NHS Foundation Trust	Guideline	15	4	Table 1 Antibiotics for diabetic foot infection in adults aged 18 years and over Response: We are concerned that this table does not reflect the complexity or scope of current practice and may be difficult to implement. The previous NICE guidelines as well as the IDSA guidelines (2012) have not mentioned specific antibiotic therapies other than targeting the most likely infecting organisms according to clinical severity. The evidence shows no difference in clinical outcomes for most antibiotic regimes, it is therefore unclear what the process involved in evidence appraisal to generate Table 1 has been. Specifically we note the following concerns. Mild infection: The dose of oral Flucloxacillin suggested seems low at 500mg four times a day, we would usually only use this for frail, elderly or relatively intolerant patients, and use 1g four times a day otherwise. The oral bioavailability of Flucloxacillin is low (approx. 50%), and in patients with a compromised peripheral blood supply due	Thank you for your comment. NICE antimicrobial prescribing guidelines are developed using the interim process and methods guide for antimicrobial prescribing guidelines. They seek to help manage common infections and tackle antimicrobial resistance. They offer evidence-based antimicrobial prescribing information and will be used to update current PHE antimicrobial prescribing guidelines. The diabetic foot infection guideline is based on a systematic review of the evidence which has been considered by the NICE committee for the development of antimicrobial prescribing guidelines (a full list of committee members are available on www.nice.org.uk). The committee discussed your comments and has changed the dosing of flucloxacillin to a range from 500 mg to 1 g for mild diabetic foot infection, and 1 g orally or 1 to 2 g IV for moderate or severe diabetic foot infection. The committee considered your comment regarding gentamicin and/or metronidazole and has amended the prescribing table to provide greater clarity regarding antibiotic choice. The

					to diabetes or peripheral vascular disease a dose of 500mg may lead to tissue drug levels lower than the Minimum Inhibitory Concentration (MIC) for the most likely infecting aerobic Gram positive organisms. Our clinical experience is that a dose of 1g is well tolerated in the majority of patients. We note the evidence appraisal has identified no evidence comparing antibiotic dose, frequency or route of administration. Moderate infection: The rationale for giving intravenous (IV) Gentamicin and/ or Metronidazole is not clear, nor the exact circumstances where they should be considered, other than the note in point 5. Gentamicin needs to be given IV, requires therapeutic drug monitoring and would therefore require hospital admission, so this guidance has implications for outpatient settings where the majority of these infections are diagnosed and managed. Often this patient cohort has significant underlying renal disease and the use of Gentamicin may outweigh the benefits in terms of the risk of renal and ototoxicity. It is unclear if Co-amoxiclav is listed as an equal alternative or 2nd line option here. We have concerns for the implications of increased Co-trimoxazole use in this patient cohort due to underlying renal disease and often increased age (increased risk of side effects), also the requirement for blood count monitoring (as per BNF) and renal function (more likely in this cohort) would have resource implications. In our experience there are a large number of patients in this cohort on diuretics, and drugs acting on the renin-angiotensin-aldosterone system, and electrolyte	decision to prescribe gentamicin and/or metronidazole with flucloxacillin, with co-amoxiclav, or with co-trimoxazole for moderate or severe diabetic foot infection should consider the risk of complications, previous antibiotic use, patient preferences and when available microbiological results to inform antibiotic choice. The committee discussed the use of co-trimoxazole and a footnote has been added to outline the need to follow relevant professional guidance, taking full responsibility for the decision and obtaining informed consent when making the decision to prescribe co-trimoxazole for the treatment of moderate or severe diabetic foot infections. A footnote has been added to the prescribing table to gentamicin and co-trimoxazole which links to the BNF which provides more information on therapeutic drug monitoring and the monitoring of patient parameters. Co-amoxiclav is one of four options for first line treatment of moderate and severe diabetic foot infection. The decision regarding whether to prescribe it with or without gentamicin, or prescribe an alternative listed antibiotic option based on clinical assessment and available microbiological results if available. Clindamycin with ciprofloxacin and/ or gentamicin has been added as a treatment option for moderate or severe infection where Pseudomonas aeruginosa is suspected or confirmed. The committee discussed your comment regarding the dosing for piperacillin-tazobactam. The prescribing table has been amended to

					disturbance is relatively common. Sufficient warning should be included. There is no mention of other agents commonly used in this setting and for this indication e.g. doxycycline, clindamycin, ciprofloxacin, levofloxacin, rifampicin and trimethoprim alone or in combination, however we note point 7. Although we agree that any use of quinolone or clindamycin should contain a careful risk assessment, we have concerns that the lack of a quinolone and clindamycin option may limit the option of a potent oral combination that may be a last resort to prevent admission or outpatient antimicrobial therapy. Severe infection The dose of piperacillin-tazobactam is listed as 8hrly, or 6 hourly in severe infection, but it is not clear what should specifically lead to the higher dose being considered.	clarify that piperacillin with tazobactam is an antibiotic choice for moderate or severe diabetic foot infection if Pseudomonas aeruginosa is suspected or confirmed only; the dose is 4.5 g three times a day IV that can be increased to 4.5 g four times a day IV which is in line with the BNF. The decision to use the higher dose should be based on clinical judgement.
38	Salford Royal NHS Foundation Trust	Guideline Choice of Antibiotics	17	2	1.6.13 When microbiological results are available: review the choice of antibiotic, and change the antibiotic according to results, using a narrow spectrum antibiotic, if appropriate. [2019] <u>Response:</u> We are concerned that this recommendation does not reflect good practice as a): it does not take into account the quality or type of clinical specimen collected, and b): the complexity involved in interpreting these microbiological results. A superficial ulcer swab may grow pseudomonas which is colonising and does not reflect the true microbiology at the base of the ulcer or under lying bone, following this recommendation may therefore lead to an inappropriate broadening or narrowing of antibiotic spectrum. From our clinical	The committee has discussed your comment and agreed that your concerns regarding good practice, the consideration of the quality or clinical specimen and the complexities in interpreting microbiological results are adequately addressed within recommendations 1.6.1 and 1.6.2 in NG19. Detail regarding this has been added to the rationale and impact section of the guideline. The committee have considered your comment about microbiological results, but no change has been made because the complexity of treatment is already taken into account in the guideline. Recommendation 1.6.14 states that the choice of antibiotic should be reviewed and changed if appropriate. Furthermore, the prescribing table states that antibiotic choice should be guided by microbiological results.

					experience, it is often very difficult to interpret diabetic foot ulcer swab, tissue or bone culture results, and interpretation is dependent upon many factors including the quality/type of clinical specimen and previous antibiotic exposure. Therefore changing antibiotics based solely on 'microbiological results' carries risk of both treatment failure and antibiotic side effects. Monitoring clinical response is often more important and highlights the importance that these infections are managed in an MDT setting. We agree that reviewing microbiology results is important, but it is not accurate to state that you must change antibiotics based on culture results alone, without taking into consideration other clinical factors.	
39	Salford Royal NHS Foundation Trust	Guideline	General	General	Our trust uses antibiotic guidelines and experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact Samantha.haycocks@srft.nhs.uk and Eamonn.trainor@srft.nhs.uk	Thank you for your comment and we will forward your details to the NICE team with responsibility for shared learning submissions. You can also request further details via nice@nice.org.uk.
40	Royal Pharmaceutical Society	Draft guideline	14	7	Why should antibiotics should start as soon as possible? If the patient is well and otherwise stable, the priority is to obtain a good quality sample to allow targeted antibiotic therapy.	Thank you for your comment. The rationale underpinning this recommendation is outlined in the rationale and impact section of the guideline. The committee discussed your comment and agreed that due to the potential for serious complications, antibiotics should be started as soon as possible if a diabetic foot infection is suspected.
41	Royal Pharmaceutical Society	Draft guideline	14	9	To support AMS there should be mention of rationalisation/ narrowing spectrum following microbiology results.	Thank you for your comment. The guideline recommendations outline that when microbiological results are available antibiotic choice should be reviewed and a changed according to results, using a narrow spectrum antibiotic if appropriate.

42	Royal Pharmaceutical Society	Draft guideline	15	4	We suggest preferential use of oral metronidazole given its good oral bio-availability.	Thank you for your comment. Oral metronidazole 400 mg three times a day is an option (in combination with ceftriaxone, flucloxacillin or co-trimoxazole with or without gentamicin) in the treatment of moderate or severe diabetic foot infection. Recommendation 1.6.10 states that when choosing an antibiotic give oral antibiotics first line if the person can take oral medication and if the severity of their condition does not require intravenous antibiotics. The guideline also states that if intravenous antibiotics are given, review by 48 hours and consider switching to oral antibiotics if possible.
43	Royal Pharmaceutical Society	Draft guideline	15	Table	For moderate infection - There is potentially quite a different spectrum of activity as a patient could be on very narrow spectrum flucloxacillin or +/- gentamicin +/- metronidazole – how is the decision made to go with very narrow spectrum flucloxacillin alone or broader spectrum flucloxacillin + gentamicin + metronidazole?	Thank you for your comment. The guideline recommendations outline that when choosing an antibiotic the decision should be informed by clinical assessment, the severity of the diabetic foot infection, the risk of developing complications, previous microbiological results, previous antibiotic use and patient preferences with a review of the need for continued antibiotics undertaken regularly. The table provides empiric choices for treatment which should be guided by microbiological results when available.
44	Royal Pharmaceutical Society	Draft guideline	15	Table	For moderate infection - when is co-amoxiclav +/- gentamicin preferred over the flucloxacillin/ gentamicin/ metronidazole.	Thank you for your comment. The guideline recommendations outline that when choosing an antibiotic, the decision should be informed by clinical assessment, the severity of the diabetic foot infection, the risk of developing complications, previous microbiological results, previous antibiotic use and patient preferences with a review of the need for continued antibiotics undertaken regularly. The table provides empiric choices for treatment which should be guided by microbiological results when available.

45	Royal Pharmaceutical Society	Draft guideline	15	Table	For moderate infection - it states first choice antibiotics for a minimum of 7 days (up to a maximum of 6 weeks) patients could potentially remain on 6 weeks of gentamicin which has both ototoxicity and nephrotoxicity concerns.	Thank you for your comment. The use of gentamicin is outlined as an optional antibiotic for moderate or severe diabetic foot infection to be used with flucloxacillin, co-amoxiclav, or with co-trimoxazole (in penicillin allergy) or with clindamycin and ciprofloxacin if pseudomonas aeruginosa is suspected or confirmed. The guideline recommends that where IV antibiotics are given, they should be reviewed by 48 hours and switched to oral antibiotics if possible, in line with Start smart then focus. A footnote has been added where gentamicin is listed as an option in the prescribing table, which links to the BNF and provides more information on therapeutic drug monitoring and the monitoring of patient parameters.
46	Royal Pharmaceutical Society	Draft guideline	15	Table	For moderate infection – it would be useful to have information on time for IV to Po switch specified in the heading (similar to severe infection).	Thank you for your comment. The guideline does not provide a specified time for switching but does outline that when choosing an antibiotic give oral antibiotics first line if the person can take them and if the severity of their condition does not require intravenous antibiotics. The guideline also recommends that if intravenous antibiotics are given, they should be reviewed by 48 hours and consider switching to oral antibiotics if possible.
47	Royal Pharmaceutical Society	Draft guideline	16	Table	For severe infection – it would be useful to have a recommendation for patients with anaphylaxis to penicillin.	Thank you for your comment. For moderate or severe diabetic foot infections co-trimoxazole with or without gentamicin and/or metronidazole is recommended in those with penicillin allergy.
48	Royal Pharmaceutical Society	Draft guideline	16	Table	For suspected MRSA infection - could teicoplanin IV also be an option? Also linezolid has 100% oral bioavailability- could this not be oral from outset- would need a warning re interactions and thrombocytopenia and the monitoring that is required for this drug. Linezolid not licensed for osteomyelitis and both SPC and evidence review only using for 4 weeks, do	Thank you for your comment. The committee considered your comment and teicoplanin has been added to the antibiotic prescribing table as an antibiotic to be added to existing antibiotic treatment if MRSA infection is suspected or confirmed. and the committee have added linezolid as an oral as well as an IV option if vancomycin or teicoplanin cannot be used or by specialist use only.

					prescribers need warning that going off label?	Linezolid is an option for MRSA cover, so is within licensed use. We do not give course lengths for IV antibiotics or MRSA cover but advise that they are reviewed by 48 hours. For MRSA treatment options we also advise that other antibiotics may be appropriate based on microbiological results and specialist advice. Furthermore, Linezolid should only be used on specialist advice and if vancomycin or teicoplanin cannot be used
49	Royal Pharmaceutical Society	Draft guideline	16	Table	For MRSA infection - Cautions around linezolid use as in diabetic foot infection course lengths may be long and there are many interactions/ contraindications plus monitoring requirements due to toxicity.	Thank you for your comment. Linezolid should only be used on specialist advice and if vancomycin or teicoplanin cannot be used. A footnote has been added to linezolid which links to the BNF and provides more information on monitoring of patient parameters.
50	Royal Pharmaceutical Society	Draft guideline	16	Table	Annotation 5 notes ‘Give oral antibiotics first-line if the person can take oral medicines, and the severity of their condition does not require intravenous antibiotics’ - It would be useful to have advice on suitable Po regimens given the move for more treatment in primary care to avoid admission.	Thank you for your comment. The committee discussed your comment and has amended the prescribing table to make antibiotic choices clearer. Oral and intravenous antibiotic choices are outlined in separate columns where available for moderate or severe diabetic foot infections. The rationale and impact sections outline that when the committee made their decision regarding the antibiotics recommended, they considered the different settings where treatment may take place.
51	FDUK – Foot in Diabetes UK	Visual Summary paper	general	general	FDUK like the format of the visual summary in general. The format provides a clear and concise tool for clinicians.	Thank you and we welcome FDUK’s contributions.
52	FDUK – Foot in Diabetes UK	Visual summary paper	Page 1	Page 1	FDUK recommend that in the Visual Summary, the middle box starting with 'Reassess if symptoms worsen ....' has an addition bullet that states: Take account of:	Thank you for your comment. The visual summary is based on the recommendations drafted by the committee. Limb ischaemia has been added to recommendation 1.6.15 about reassessment and has been added the visual summary section on reassessment.

					• limb ischaemia, that may mask the usual signs of infection in the foot / leg	
53	FDUK – Foot in Diabetes UK	Visual summary paper	Page 2	general	A clearer definition of mild/moderate/severe infection would be helpful - it is suggested that IDSA definitions are used. Should there be a separate section for osteomyelitis - with 1st line treatment, 2nd line (no mention of clindamycin which is widely used)?	Thank you for your comment. The visual summary provides a brief overview of the background information and terms used. Due to restricted space within the template it is not possible to provide a fuller outline of the definitions. Fuller definitions derived from the IDSA definitions are outlined in the full guideline document. The evidence review that underpins the guideline defines diabetic foot infection as including osteomyelitis. The identified studies within the evidence review did not always disaggregate those with osteomyelitis from diabetic foot infections. Clindamycin with ciprofloxacin and/ or gentamicin has been added as an option for the treatment of moderate or severe infection where Pseudomonas aeruginosa is suspected.
54	FDUK – Foot in Diabetes UK	Visual summary paper	Page 2	general	For moderate infection, most current guidelines state that the starting dose should be; Flucloxacillin 1g QDS and for IVs 2g QDS.	Thank you for your comment. The committee have discussed your comment and the prescribing table has been amended to outline that flucloxacillin should be prescribed 1 g four times a day orally or 1 to 2 g four times a day intravenously.
55	FDUK – Foot in Diabetes UK	Visual summary paper	Page 2	general	FDUK suggest there should be a separate section for osteomyelitis, stating 1st and 2nd line treatment.	Thank you for your comment. The evidence review that underpins the guideline defines diabetic foot infection as including osteomyelitis. The identified studies within the evidence review did not always disaggregate those with osteomyelitis from diabetic foot infections. The committee recognises that osteomyelitis can be clinically distinct, but given the evidence considered and that antibiotic treatments do not differ due to the presence of osteomyelitis they have not changed the guideline.

56	FDUK – Foot in Diabetes UK	Visual summary paper	Page 2	general	It is noted that Clindamycin is not included in the guideline which is a widely used antibiotics, particularly in the management of osteomyelitis.	The committee discussed the use of clindamycin and it has now been added to the prescribing table as an antibiotic option (with ciprofloxacin and/ or gentamicin) for moderate or severe infection if pseudomonas aeruginosa is suspected or confirmed
57	FDUK – Foot in Diabetes UK	Draft Guideline	Pages 7 and 8	general	FDUK has concerns that the terms 'ischaemia' and 'limb ischaemia' are (as usual) somewhat ambiguous. This could result in delayed detection and untimely management, particularly with the lethal combination of severe / critical ischaemia and infection together. FDUK suggests that any NICE diabetes foot guidance helps the clinician to assess, recognise and differentiate between 'non-critical ischaemia' and 'critical ischaemia'. It may be useful to summarise the 2 terms using established clinical assessment thresholds in the available clinical literature: Non-critical ischaemia Non palpable OR monophasic foot pulses AND ABPI < 0.9 / > 1.3 OR TBPI < 0.7 Critical ischaemia Non palpable / monophasic foot pulses AND Rest pain in toes or foot for > 2 weeks OR Ankle pressure < 50 mmHg / Toe pressure < 30 mmHg	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations (for example 1.3 Assessing the risk of developing a diabetic foot problem) as we have not reviewed the evidence regarding these.
58	FDUK – Foot in Diabetes UK	Draft Guideline	Page 8	Line 4	FDUK recommend NICE to consider that the term 'Active Diabetic Foot Problem:' be revised to 'Active Diabetic Foot Problem (risk of amputation):'	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic

						foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations (for example 1.3 Assessing the risk of developing a diabetic foot problem) as we have not reviewed the evidence regarding these.
59	FDUK – Foot in Diabetes UK	Evidence Review	Page 6	General Background	Under background, FDUK suggest that it includes a statement which acknowledges that ischaemia may mask the clinical signs of infection and that this should be taken into account when assessing for and managing infection.	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations (for example 1.3 Assessing the risk of developing a diabetic foot problem) as we have not reviewed the evidence regarding these.
60	London Diabetes Clinical Network	Guideline	16	Table 1	We are concerned that there is a possible contradiction; “Review IV antibiotics by 48 hours and switch to oral antibiotics” seems at odds with the guidance for Moderate and Severe Infections “first choice antibiotics for a minimum of 7 days (up to 6 weeks for osteomyelitis) eg Flucloxacillin with Gentamycin.	Thank you for your comment. The guideline outlines that oral antibiotics should be considered first-line if the person can take oral medicines, and if the severity of their condition does not require intravenous antibiotics. The guideline also outlines that intravenous antibiotics be reviewed by 48 hours and consider switching to oral antibiotics if possible. The committee have considered your comment further and do not think there is a contradiction and has not changed the guideline. They agree that for those with moderate and severe infections switching to oral treatment may not always ‘be possible’ but consider the reviewing of IV antibiotics at 48 hours good practice that supports antimicrobial stewardship.
61	London Diabetes Clinical Network	Guideline	15	Table 1	We are concerned that gentamycin is considered the second additional drug in moderate infection. This requires inpatient care or access to OPAT which is sadly lacking in reality. The consequence of this is;	Thank you for your comment. The use of gentamicin is outlined as an optional antibiotic choice that can be added to flucloxacillin, co-amoxiclav or co-trimoxazole in moderate or severe diabetic foot infection or with clindamycin and ciprofloxacin if pseudomonas aeruginosa is

					1) Patients not given a second line drug 2) All patients with moderate infection requiring referral to infectious disease teams/OPAT (and their capacity) 3) Increase in litigation if Gentamycin is not used (as it is outlined as the second addition in the guidance) Could Metronidazole be considered before Gentamycin?	suspected or confirmed. The committee have added an option for ceftriaxone with metronidazole for people with moderate or severe diabetic foot infection. A footnote has been added which links to the BNF and provides more information on therapeutic drug monitoring and the monitoring of patient parameters
62	London Diabetes Clinical Network	Guideline	15	Table 1	We are concerned that there is no guidance where these antibiotics should be administered. Should there be different options for inpatient, OPD and community due to likely availability? What is practical?	Thank you for your comment. We have not made recommendations on care setting as this is not the remit of antimicrobial prescribing guidelines. The committee have taken care to provide antibiotic options that can be used in different care settings, taking into account the severity of the infection.
63	London Diabetes Clinical Network	Guideline	15	Table 1	We are concerned that the monitoring of Co-Trimoxazole should be made more apparent as many patients with diabetes have renal disease.	Thank you for your comment. The committee discussed your comment and the prescribing table has been amended with footnotes added that link to the BNF and provide more information on therapeutic drug monitoring and the monitoring of patient parameters.
64	London Diabetes Clinical Network	Guideline	15	Table 1	There is no information regarding when to add a second or third antibiotic eg Flucloxacillin + Gentamycin + Metronidazole. If patients are blanketed routinely with all three drugs will this defeat the object of antibiotic stewardship?	Thank you for your comment. The guideline outlines that when initiating treatment antibiotic choice should be based on clinical assessment and guided by microbiological advice when available, with consideration given to the severity of the infection, the risk of complications, previous microbiological results, previous antibiotic use and patient preferences.
65	Midlands Partnership Foundation Trust	General	General	General	Thank you to the committee for focussing on the issue of diabetic foot infection. I am pleased this section of the national guidance will provide more specific regarding prescribing guidance, although it does raise concerns regarding the NICE review timescales versus review timescales for more local prescribing guidance in the	Thank you for your comment. NICE antimicrobial prescribing guidelines are developed using the interim process and methods guide for antimicrobial prescribing guidelines. Within this there is an process for ensuring that published guidelines are current and accurate and for updating guidelines. NICE adopts a proactive approach which includes reacting to events as

					NHS setting. Perhaps there should be a more frequent update for this section?	they occur as well as a standard check every 5 years.
66	Midlands Partnership Foundation Trust		Pg 15 17	General comments about this section.	In the case of the diabetic foot it is a shame that wound sampling and microbiology findings do not necessarily reflect the causative organism(s). 'Treating the swab', rather than treating the person is a common problem in practice. It would be very helpful to include a recommendation which reinforces this critical message, including the fact that that infection is a clinical diagnosis, not diagnoses by swab. It would also be beneficial to outline bloods and serial imaging for monitoring of osteomyelitis.	Thank you for your comment. NG19 contains recommendations which were not updated as part of this review on swabbing and imaging (recommendations 1.6.1 and 1.6.2). We have included recommendations that state that when microbiological results are available the choice of antibiotic should be reviewed and changed if appropriate. The recommendations also outline that many factors should be taken into account when choosing an antibiotic, not just swab results ((recommendation 1.6.7)
67	Midlands Partnership Foundation Trust	WHO 20th Essential Medicines List 2017	P9 24	General comments about this section.	The accompanying rationale states 'recommendations aim to optimise antibiotic use and reduce antibiotic resistance.' When compared with the draft antibiotic guidance with WHO 20th Essential Medicines List 2017 we note that Clarithromycin and Erythromycin are both in the WATCH group, due to higher resistance potential. Doxycycline remains in the ACCESS group, and perhaps this could be highlighted as the most appropriate non-penicillin first line, other than in pregnancy of course.	Thank you for your comment. The prescribing tables have been amended to provide greater clarity regarding antibiotic choices with choices for mild diabetic foot infections separated from the choices for moderate and severe diabetic foot infections. Clarithromycin, erythromycin and doxycycline are all alternative oral antibiotic choices for mild diabetic foot infections for penicillin allergy or if flucloxacillin is unsuitable and do not represent 1st, 2nd and 3rd line choices. They are all options, except in pregnancy, that can be selected based on clinical assessment and guided by microbiological results when available.
68	Midlands Partnership Foundation Trust		Pg 15 and 16	Point 4 table 1.	We found the antibiotic table difficult to understand initially due to the 'with or without', and 'and/or'. It might be useful to separate the sections or use shades of grey to split up the alternatives within each section to avoid potential confusion.	Thank you for your comment. The committee discussed your comment and have amended the prescribing table in line with NICE style to provide greater clarity regarding antibiotic choice.
69	Midlands Partnership Foundation Trust		Pg 15 and 16	Point 4 Table 1	This is a big concern for impact upon practice. The inclusion of Gentamycin given IV, rather than an alternative oral medication, unfortunately does not reflect the context for management of most	Thank you for your comment. The use of gentamicin is outlined as an optional antibiotic choice for moderate or severe diabetic foot infection which can be used with flucloxacillin, co-amoxiclav or with co-trimoxazole (in penicillin

70					diabetic foot infections. Most cases will be managed in an outpatient, or increasingly, in a community setting. This is recognised by the NG19 guidance document. An oral alternative to Gentamycin really is required, especially as the draft guidance itself indicates step down from IV to oral therapy as soon as reasonable for severe infections, and the accompanying rationale document states "In line with the NICE guideline on antimicrobial stewardship and Public Health England's Start Smart – then Focus, the committee agreed that oral antibiotics should be used in preference to intravenous antibiotics where possible. Intravenous antibiotics should only be used for people who are severely ill, unable to tolerate oral treatment, or where oral treatment would not provide adequate coverage or tissue penetration. The use of intravenous antibiotics should be reviewed by 48 hours (taking into account the person's response to treatment and any microbiological results) and switched to oral treatment where possible". Unfortunately I was unable to access the link for "evidence review X" in the rational document as 'the page was not found', as we appreciate this may have provided further explanation regarding the committee's reasoning for this decision. Across the West Midlands Rifampicin has generally been used with Flucloxacillin and Metronidazole.	allergy) or with clindamycin and ciprofloxacin if pseudomonas aeruginosa is suspected or confirmed. The antibiotic table has been amended to make this clearer. The committee has not changed the reference to gentamicin as it is an option that can be added used based on clinical assessment and microbiological results when available. A footnote has been added which links to the BNF and provides more information on therapeutic drug monitoring and the monitoring of patient parameters.
70	Midlands Partnership Foundation Trust		Pg 13 section 1.6 "Diabetic foot infection."		Could the management of infection section also mention the use of antimicrobial dressings in addition to antibiotic therapy?	Thank you for your comment. Dressings are beyond the scope of the antimicrobial prescribing aspects of this guideline and the evidence regarding this has not been considered.

71	Countess of Chester NHS Foundation Trust	Visual summary	general	general	This recommendation will be a challenging change in practice because it will likely result in increased use of IV abx and will result in a need to increase capacity for H@H services or will increase hospital admissions	Thank you for your comment. The committee discussed your comment and has amended the prescribing table to make both oral and IV antibiotic choices for the treatment of mild, moderate and severe diabetic foot infections clearer. The rationale and impact sections outline that when the committee made their decision regarding the antibiotics recommended, they considered the different settings where treatment may take place.
72	Countess of Chester NHS Foundation Trust	Evidence review	25	19	Is the move away from clindamycin a result of overall evidence suggesting reduced efficacy?	Thank you for your comment. The committee discussed the use of clindamycin and it has now been added to the prescribing table as a choice for moderate or severe diabetic foot infection if pseudomonas aeruginosa is suspected or confirmed.
73	Countess of Chester NHS Foundation Trust	Evidence review	95	Appendix G	Lipsky et al. (1990) clindamycin vs cephalexin is very low quality evidence therefore should be used with caution	Thank you for your comment. The NICE antimicrobial prescribing guidelines are developed using the interim process and methods guide for antimicrobial prescribing guidelines and the committee have considered the quality of the evidence when developing the guideline.
74	NHS England	Foot protection service	general	general	This will be a new service and needs to be set up under Choose and Book with enough capacity to enable it to respond to referrals in primary care within the recommended timeframes. (ET)	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations (for example 1.2.1 which refers to a 'foot protection service') as we have not reviewed the evidence regarding these.
75	NHS England	MDT urgent foot service	General	general	The timescales for urgent referral are challenging. The service administrator should have a direct dial phone number or mobile to enable a GP or PN to make contact. The development of a complicated referral form by the service should be	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which included table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on

					resisted and a computer notes summary should be preferred.	antimicrobial prescribing. We cannot respond to comments on the other recommendations (for example 1.4 which covers referral) as we have not reviewed the evidence regarding these.
76	NHS England	Inclusivity	general	general	This will need to be a 7 day service or valuable time will be lost. (ET)	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which includes table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations or their implications as we have not reviewed the evidence regarding these.
77	NHS England	Practice Nurse communication	General	General	Many of the people requiring these services will be house bound or very limited mobility, especially during times of infection. The use of IT to enable virtual consultations with the support of the District Nursing service should be explored.	Thank you for your comment. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which includes table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations or their implications as we have not reviewed the evidence regarding these.
78	NHS England	General presentation	general	general	Or a domiciliary facility.	Thank you for your comment. It is unclear what your comment refers to. This stakeholder consultation invited comments on the new and updated recommendations (1.6.6 to 1.6.15) which includes table 1 (antibiotics for diabetic foot infection in adults aged 18 years and over) only. Recommendations 1.6.6 to 1.6.15 do not preclude the consideration of domiciliary settings for treatment and this decision should be made locally based on local circumstances and information. We have only reviewed evidence on antimicrobial prescribing. We cannot respond to comments on the other recommendations.

79	NHS England		gener al	general	The guideline details the need for reassessment if symptoms deteriorate rapidly or significantly, such issues will frequently be managed by Podiatrists who at the current time do not offer 7-day services, timely reassessment may not therefore be possible . Should there be any reference here to advising patients to seek urgent medical advice either from their GP or Urgent care if their symptoms do not improve of they become systemically unwell? (SC)	Thank you for your comment. The committee chose not to say who should reassess due to the variety of care models in place. There is a recommendation about providing advice to people with a diabetic foot infection on seeking medical help if symptoms worsen rapidly or significantly at any time or do not start to improve within 1 to 2 days and the committee felt that this provided sufficient signposting to appropriate care,
80	Scottish Antimicrobial Prescribing Group (SAPG), Healthcare Improvement Scotland	Guideline	14	1.6.6	We challenge the comment that antibiotics should start as soon as possible. If the patient is well and otherwise stable, the priority is to obtain a good quality sample to allow targeted antibiotic therapy. This should be a clinical decision based on severity/ clinical need. Often antibiotics can wait until a decent sample has been taken if no sepsis/systemic upset. There should also be emphasis on rationalisation/ narrowing spectrum following micro results which is really important from an AMS point of view. There is a very recent publication on AMS in DFI which may not have been considered. It would be useful for NICE to consider and include Curr Opin Infect Dis. 2019 Apr;32(2):95-101. doi: 10.1097/QCO.0000000000000530. Principles and practice of antibiotic stewardship in the management of diabetic foot infections.	Thank you for your comment and reference. The rationale underpinning the recommendation is outlined in the guideline. The committee discussed your comment and has agreed that due to the potential for serious complications antibiotics should be started as soon as possible if a diabetic foot infection is suspected. The guideline outlines that when microbiological results are available antibiotics should be changed according to the result, using a narrow spectrum antibiotic if appropriate. Thank you for highlighting the Uckay et al (2019) reference which was published after our search cut-off date and therefore it has not been considered within the evidence review or the subsequent guideline. When the guideline is considered for update searches will be re-run, any additional references will be considered, and a decision made on whether the guideline requires an update or not.
81	Scottish Antimicrobial Prescribing Group (SAPG), Healthcare	Guideline	15	Table 1	The choice of antibiotics for moderate and severe infection varies from practice in Scotland. Ceftriaxone would not be used outwith OPAT and pip-taz is restricted so only used on advice of microbiologist.	Thank you for your comment. Ceftriaxone with metronidazole is one of four antibiotics that can be used for the treatment of moderate and severe diabetic foot infection and is appropriate for use in OPAT settings. The rationale and

	Improvement Scotland				However acknowledge there is evidence supporting pip-taz use in DFI. There should be a note regarding the preferential use of oral metronidazole given its great oral bio-availability. It still gets preferentially used IV far too often. NICE endorsement of the oral route would be useful. There should be caveats regarding linezolid use as in DFI course lengths may be long in view of the many interactions/ contraindications and monitoring requirements due to toxicity.	impact sections outline that when the committee made their decision regarding the antibiotics recommended, they considered the different settings where treatment may take place. Oral metronidazole has been added as an option for all moderate and severe infection choices. Additionally, the guideline outlines that when choosing an antibiotic, give oral antibiotics first line if the person can take oral medication and if the severity of their condition does not require intravenous antibiotics. The guideline also states that if intravenous antibiotics are given, review by 48 hours and consider switching to oral antibiotics if possible. Currently linezolid is only an option if vancomycin cannot be used and/or based on specialist advice. The committee have considered the point you raised regarding interactions, contraindications and potential toxicity but agreed that linezolid is an appropriate antibiotic choice for diabetic foot infection. A footnote has been added which links to the BNF and provides more information on monitoring of patient parameters.