

READING SUB-TEST – TEXT BOOKLET: PART A**CANDIDATE NUMBER:****LAST NAME:****FIRST NAME:****MIDDLE NAMES:****PROFESSION:****VENUE:****TEST DATE:**

Candidate details and photo will be printed here.

Passport Photo

CANDIDATE DECLARATION

By signing this, you agree not to disclose or use in any way (other than to take the test) or assist any other person to disclose or use any OET test or sub-test content. If you cheat or assist in any cheating, use any unfair practice, break any of the rules or regulations, or ignore any advice or information, you may be disqualified and your results may not be issued at the sole discretion of CBLA. CBLA also reserves its right to take further disciplinary action against you and to pursue any other remedies permitted by law. If a candidate is suspected of and investigated for malpractice, their personal details and details of the investigation may be passed to a third party where required.

CANDIDATE SIGNATURE: _____**INSTRUCTIONS TO CANDIDATES**You must **NOT** remove OET material from the test room.

Managing diabetic foot ulcers: Texts

Text A

Assessing a diabetic foot ulcer

The clinical management of a diabetic foot ulcer (DFU) will depend on what type it is, and this must be determined before a care plan is put into place.

	Neuropathic	Ischaemic	Neuroischaemic
Sensation	sensory loss	painful	degree of sensory loss
Callus/necrosis	callus present and often thick	necrosis (dead tissue) common	minimal callus prone to necrosis
Wound bed	pink and granulating	pale and sloughy, poor granulation	poor granulation
Foot temperature and pulses	warm with bounding pulses	cool with absent pulses	cool with absent pulses
Other	dry skin and fissuring	delayed healing	high risk of infection
Typical location	weight bearing areas of the foot such as metatarsal heads, the heel and over the dorsum of clawed toes	tips of toes, nail edges and between the toes and lateral borders of the foot	margins of the foot and under toe nails
Prevalence	35%	15%	50%

Text B

Applying dressings to DFUs:

- Avoid bandaging over toes as this may cause a tourniquet effect (instead, layer gauze over the toes and secure with a bandage from the metatarsal heads to a suitable point on foot)
- Use appropriate techniques (e.g. avoiding creases and being too bulky) and take care when dressing weight-bearing areas
- Avoid strong adhesive tapes on fragile skin
- Avoid tight bandaging at the fifth toe and the fifth metatarsal head (trim the bandage back)
- Ensure wound dead space is eliminated (e.g. use a dressing that conforms to the contours of the wound bed)
- Remember that footwear needs to accommodate any dressing. Wounds should be cleansed at each dressing change and after debridement with a wound cleansing solution or saline. Cleansing can help remove devitalised tissue, re-balance the bioburden and reduce exudate to help prepare the wound bed for healing.

For infected or highly exuding DFUs, inspect the wound and change the dressing daily, and then every two or three days once the infection is stable. A different type of dressing may be needed as the status of the wound changes. Patients should be encouraged to look out for signs of deterioration, such as increased pain, swelling, odour, purulence or septic symptoms. In some cases (e.g. in the first few days of antibiotic therapy) it is a good idea to mark the extent of any cellulitis with an indelible marker and tell the patient to contact the footcare team immediately if the redness moves substantially beyond the line.



Text C

Debridement of DFUs

The first priority of management of foot ulceration is to prepare the surface and edges of a wound to facilitate healing. If foot pulses are present, non-viable tissue should be removed from the wound bed and surrounding callus removed. If foot pulses are absent, assessment and management of the peripheral vasculature is mandatory before removal of non-viable or necrotic tissue is considered. Referral to a vascular surgeon is suggested in this situation. Removal of non-viable tissue can be quickly and effectively accomplished by local sharp debridement.

Sharp debridement should be carried out by experienced practitioners (e.g. a specialist podiatrist or nurse) with specialist training and the plan and expected outcome discussed with the patient in advance. Debridement should remove all devitalised tissue, callus and foreign bodies down to the level of viable bleeding tissue. It is important to debride the wound margins as well as the wound base to prevent the 'edge effect', whereby epithelium fails to migrate across a firm, level granulation base. Practitioners must explain fully to patients the risks and benefits of debridement in order to gain their informed consent.

Text D

Dressings for DFUs	Advantages	Disadvantages
Low-adherence	simple, hypoallergenic, inexpensive	minimal absorbency
Hydrocolloids	absorbent, can be left for several days, aid autolysis	concerns about use for infected wounds, may cause maceration, unpleasant odour
Hydrogels	absorbent, aid autolysis, donate liquid	may cause maceration
Foams	thermal insulation, good absorbency, conform to contours	occasional dermatitis with adhesive
Alginates	highly absorbent, bacteriostatic, hemostatic, useful for packing deep wounds	may need wetting before removal
Iodine preparations	antiseptic, moderately absorbent	iodine allergy, discolours wounds, cost, not suitable in case of thyroid disease or pregnancy
Silver-impregnated	antiseptic, absorbent	cost

END OF PART A
THIS TEXT BOOKLET WILL BE COLLECTED



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