



RESPONSE TO COMMENT ON RASMUSSEN ET AL.

A Randomized Controlled Trial Comparing Telemedical and Standard Outpatient Monitoring of Diabetic Foot Ulcers. *Diabetes Care* 2015;38:1723–1729

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Knud Bonnet Yderstraede,¹
Johnny Froekjaer,² and
Benjamin Schnack Brandt Rasmussen¹

We appreciate the comments made by Muller et al. (1) to our recent article in *Diabetes Care* (2). Their findings corroborate those of ours, including the logistics for dissemination of technology, the lack of ownership among the number of stakeholders in a complex setup, the need for patient stratification to define particular subgroups that might or might not benefit from telemedical monitoring, and other aspects.

The lack of difference in mortality in the research data from the Medico-economical Assessment of Telemedicine During Chronic Diabetes-related Foot Wound Management (AIRPEDIA) can, as mentioned in the article by Muller et al. (1), be explained by the lack of randomization, and we consider randomization a major strength in our study. We furthermore acknowledge certain weaknesses in our setup.

We fully agree that telemedicine is a potential beneficial mode for monitoring ulcers of various etiologies. We have to bear in mind that different types of ulcers require different treatment strategies; thus, a uniform eHealth solution cannot be expected to cover all kinds of ulcers. Furthermore, telemedical monitoring has to be compared with usual provided health care, making it a supplemental tool and more likely to obtain success in rural areas with large distances to health care providers with no alternative options.

Also, we recommend the use of the Model for ASsessment of Telemedicine

applications (MAST) (3) as the common platform for evaluating regimes used in telemedicine because this model includes seven important domains to be considered. In general, clinical effectiveness does not equal economical savings. New technologies are expensive in the establishing phase and upgrading is needed during an implementation phase.

The use of telemedicine in wound handling has been addressed in a recent survey under the auspices of EWMA (European Wound Management Association) (4), which underlines the need for further clinical studies to assure patient satisfaction and empowerment, economy, durability, transferability, and patient safety.

The study by Charpentier et al. (5) on the use of Diabeo software illustrates the successful use of a telemedical monitoring system in the handling of glycemic control among adult patients with type 1 diabetes. In our opinion, this is a much less complicated area to introduce telemedicine and the study nicely illustrates the feasibility in this setup.

Conclusively, we are satisfied that our results are corroborated by others in the sense that telemedicine basically holds much promise, but the dissemination should be substantiated by clinical studies to avoid potential unfortunate outcomes. The process should be an iterative one with continuous learning and corrections to be implemented accordingly. We

should oppose the political incentive to use telemedicine for cost savings and instead advocate for a joint venture in which clinicians define their needs for technology and offer their assistance in clinical studies.

Duality of Interest. No potential conflicts of interest relevant to this article were reported.

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¹Department of Medical Endocrinology, Odense University Hospital, Odense, Denmark

²Department of Orthopaedic Surgery, Odense University Hospital, Odense, Denmark

Corresponding author: Knud Bonnet Yderstraede, knud.yderstraede@rsyd.dk.

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