

Revisiting the Total Contact Cast

Maximizing off-loading by wound isolation

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Although the benefits of total contact casting for healing plantar neuropathic ulcers are consistent throughout a large body of available literature, the method of cast application varies (1–17). Cast structure at the ulcer site provides one major variance, i.e., should the cast create total contact with the entire plantar surface of the foot or should the wound be isolated? This article aims to resolve this issue by examining the differences in plantar pressure at the wound site between total contact casting using full contact with the plantar aspect of the foot and wound isolation.

RESEARCH DESIGN AND METHODS

— A total of 10 healthy adult subjects (aged 28 ± 13 years, height 1.81 ± 0.1 m, and weight 92.6 ± 18 kg) with focal areas of pressure (but no history of ulceration) under their metatarsal heads were recruited. For each subject, a region of interest (ROI) was selected to encompass areas of particularly high pressure. This study was approved by the Institutional Review Board of the Cleveland Clinic Foundation, and all subjects signed informed consent forms. A Pliance pressure-sensitive array (Novel) was fixed directly to the subject's foot covering the ROI. The 16×16 sensor array had a sensor size of 19.36 mm^2 and a sampling rate of 50 Hz.

Subjects were timed while they

walked 10 m barefoot with the sensor held in place using thin paper tape. The pace was self-selected but measured to provide reproducible speeds under the different conditions. The subjects were then cast with the sensor in place over the ROI using one of two casting methods, A or B, selected at random. Casting method A created a true total contact cast (TCC), and casting method B created a wound-isolation TCC (Fig. 1). Details of casting techniques are provided in the online appendix (available at <http://care.diabetesjournals.org>). Both methods presented here used fast-setting fiberglass cast materials (3M Health Care). All casts were applied by the same trained personnel with previous TCC experience.

Once the subject was comfortable walking in the cast, he/she was timed walking 10 m in the cast while pressure data were recorded. After the data were collected, the cast was removed with an oscillating cast saw, taking care to avoid moving or damaging the embedded sensor. The second type of cast was then immediately applied with the sensor array fixed in the same position, and the data collection procedure was repeated.

Five steps from the middle portion of the walk were averaged for each trial using Novel step analysis and averaging software. A 5-cm diameter circular area was identified near the center of the sensor array such that

it included the ROI selected for each patient. The peak pressure and pressure-time integral in these regions were calculated. The same regions were used to examine data from barefoot walking, walking in a conventional TCC without wound foam, and walking in a wound-isolation TCC with wound foam. Time-matched trials were used for comparison to eliminate the effects of speed on plantar pressure.

RESULTS— The measured in-cast pressures varied with method of application but were, in general, equivalent to results from prior work done using a similar application technique, despite the higher sensor resolution used in the present work, which tends to record greater pressures. The conventional TCC reduced peak pressures to 98 ± 30 kPa, results similar to those reported by Hartsell et al. (15). The wound-isolation TCC reduced peak pressures to 60 ± 16 kPa, results similar to those of Shaw et al. (16). Paired student's *t* tests found a significant lowering of peak pressure by 39% ($P = 0.008$) and pressure-time integral by 25% ($P = 0.012$) compared with the conventional TCC.

CONCLUSIONS— Although high barefoot peak pressures have been linked to longer ulcer healing times, there is no quantitative in-cast pressure threshold for ulcer healing. Even without the benefit of such a threshold, it is reasonable to suggest that clinicians should take any means available to lower plantar pressure during the healing process.

One of the theoretical drawbacks to the creation of a wound cavity is pressure concentration at the cavity edges. This phenomenon was not visible in any of the subjects' pressure distributions. A representative group of pressure distributions displaying no sign of a ring of elevated pressure is shown in Fig. 1. The same result was previously noted by Shaw et al. (16). We believe that pressure concentration is avoided in the wound-isolation TCC by skiving the foam to create a cavity that is more bowl-like than cylindrical. No conclusions about load transfer can be drawn from

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Abbreviations: ROI, region of interest; TCC, total contact cast.

A table elsewhere in this issue shows conventional and Système International (SI) units and conversion factors for many substances.

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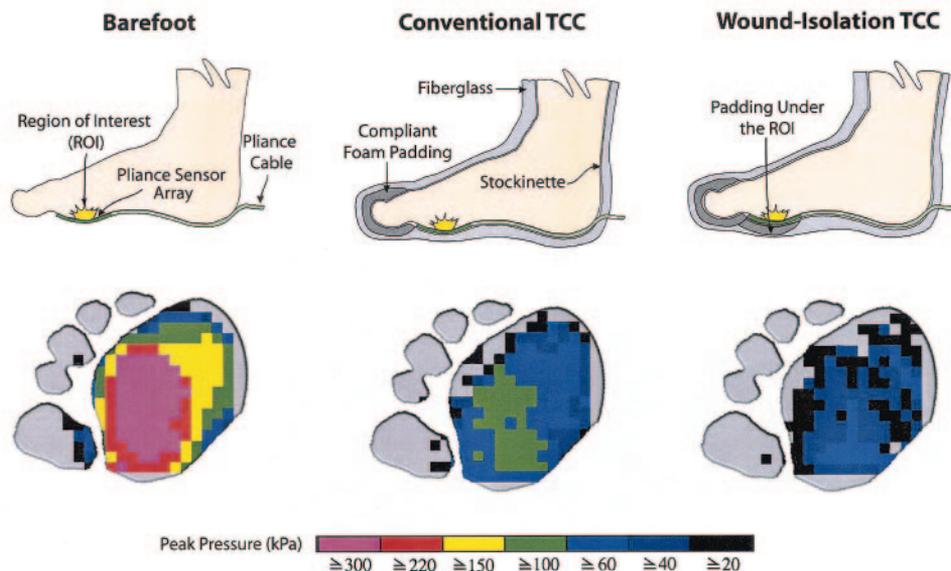


Figure 1—Schematic representation of the casting methods shown with representative pressure distributions from subject 8.

this study. It is likely that more load was being carried by the midfoot, heel, and/or leg to reduce load, and therefore pressure, on the area of plantar prominence. A larger sensor, such as the Pedar (Novel) would be able to answer this question at the expense of decreased spatial resolution.

The results of this study are, at present, limited to submetatarsal head plantar prominences and associated ulcers. Further exploration of the efficacy of wound isolation in cases of midfoot and heel ulceration is required before similar recommendations can be made for ulcers occurring in these regions. Although casting is a technique prone to variation, plantar pressure measurements within TCCs have been shown to have high repeatability when the casts are applied by experienced technicians (17).

This experiment suggests that the name “total contact cast” is somewhat of a misnomer. To optimize wound off-loading, the cast should provide total contact everywhere except for the wound site, which should be mechanically isolated. These results should be confirmed in a clinical study, which, if other factors (such as patient activity level and ulcer characteristics) are matched, could be expected to show faster healing times in the wound-isolation cast.

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