



applicable. Here, we will only report some specific aspects about the offloading treatment at different levels of infection and ischaemia, with data from our systematic review included.

Our systematic review identified one controlled study, supported by 3 non-controlled studies, that found non-removable knee-high devices versus removable devices may cause large increases in proportion of infected ulcers healed (adjusted OR 2.53, 1.19-5.35; Low CoE) (11). In our expert opinion, we consider such an outcome is likely in all plantar forefoot or midfoot DFUs complicated by either mild infection or mild ischaemia, or mild-to-moderate amounts of exudate (11). The improved healing is likely to be associated with increased levels of adherence for non-removable versus removable devices. It is possible that if removable devices were worn more frequently, there would be similar levels of healing between the devices. Furthermore, in our expert opinion, the presence of mild infection or mild ischaemia should not affect the resources required, cost-effectiveness, equity, acceptability and feasibility considerations for non-removable versus removable offloading devices as outlined in the rationale for Recommendations 1 and we refer the reader to those judgements. We do stress that when the ulcer is infected or ischaemic, it should be monitored more regularly via at least weekly visits to a healthcare professional, to enable the device to be removed and the ulcer and any infection checked. However, clearly more research is needed to investigate the use of non-removable knee-high devices compared to removable devices for healing a plantar forefoot or midfoot DFU complicated by either mild infection or mild ischaemia.

Non-removable offloading should not be used when both mild infection and mild ischaemia, moderate infection or ischaemia, or heavy exudate is present and these conditions require frequent inspection or wound care, potentially daily (11). Removable offloading devices can be considered for healing these ulcers, and we recommend any removable offloading device as per Recommendation 2, although note that one controlled study found removable knee-high devices may cause moderate increases in ulcers healed in people with infection compared to removable ankle-high devices (26). However, if the ulcer does not require daily inspection or wound care, but only removal of the device with certain indications (e.g. fever present) or otherwise at weekly clinic visits, a knee-high removable device may be rendered non-removable to promote adherence and efficacy. This should only be provided as long as the circumferential wrapping or other closure technique used can be removed and applied at any time, by a homecare professional or a trained partner.

If a neuropathic plantar forefoot or midfoot ulcer is complicated by both moderate infection and moderate ischaemia, or by severe infection or severe ischaemia, then the infection or ischaemia treatment should be planned first before determining the appropriate offloading intervention. This may mean the person remain fully non-weight-bearing during a period that the infection or ischaemia treatment prohibits the use of offloading. However, in cases where a person will be weight-bearing prior to resolution of the infection or severe ischaemia, the best offloading option that will work in conjunction with infection and/or ischaemia interventions should be implemented. As no evidence exists for offloading these severe infection or ischaemic complications, in our expert opinion, the choice of removable offloading intervention needs to consider a patient's individual factors, such as, their function, ambulatory status, and activity level. When the infection and ischaemia status improve, the recommendations for mild to moderate infection or ischaemia apply (Recommendations 7a and 7b), or, when the infection or ischaemia are resolved, the recommendations for non-complicated foot ulcers