DWC Diabetic Wound Care Prep

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Practice Questions

Try all 30 first, then check the answer key at the back.

1. A 78-year-old with mild dementia, diabetic foot ulcer, and poor glycemic control lives alone. What is the appropriate management?

A. Provide large-print written education aids
B. Hospitalize for hyperglycemia management
C. Schedule daily outpatient supervisory visits
D. Simplify regimen and order home health services

2. A referral involves a stable, shallow diabetic foot ulcer with good perfusion. What is the appropriate triage decision?

A. Redirect to local outpatient wound care clinic
B. Accept transfer to tertiary limb salvage unit
C. Admit directly to vascular surgery service
D. Schedule urgent emergency department visit

3. An obese patient with a non-healing DFU reports good intake. Which finding best identifies a risk for occult malnutrition?

A. Serum albumin level of 3.8 g/dL
B. Stable Hemoglobin A1c level of 7.5%
C. Serum prealbumin level of 12 mg/dL
D. Body Mass Index calculated above 30

4. A hospital system implements a multidisciplinary limb salvage team. Which primary metric indicates the clinical effectiveness of this care model?

A. Increased patient referral volume
B. Reduced cost per wound dressing
C. Shorter wait for initial appointments
D. Higher patient satisfaction scores

5. A patient with a DFU and type 2 diabetes starts high-dose prednisone. What is the priority management step?

A. Initiate prophylactic antibiotic therapy
B. Proactively increase insulin therapy dosage
C. Maintain current oral hypoglycemic agents
D. Discontinue corticosteroid therapy rapidly

6. A patient with no structural foot deformities has a third recurrence of a plantar ulcer despite previous healing. Which referral addresses the likely root cause?

A. Infectious disease for suppression
B. Plastic surgery for flap reconstruction
C. Orthotics for charcot restraint walker
D. Case management and social work

7. Triage the following patients: Patient A has stable dry gangrene of the toe (no systemic signs); Patient B has crepitus and fever.

A. A to vascular clinic; B to emergency
B. Both patients to emergency department
C. A to emergency; B to vascular clinic
D. Both patients to the outpatient wound care center

8. An 80 kg patient has a large, draining sacral ulcer. Using standard injury factors for chronic wounds (30-35 kcal/kg), what is the estimated daily energy requirement?

A. Approximately 3500 to 4000 kcal per day
B. Maintain current intake of 1800 kcal
C. Approximately 2400 to 2800 kcal per day
D. Approximately 1600 to 2000 kcal per day

9. A patient with a non-healing diabetic foot ulcer has an Ankle-Brachial Index (ABI) of 0.45. Which intervention is indicated?

A. Routine wound care follow-up
B. Application of compression wraps
C. Referral for physical therapy
D. Continue current topical therapy

10. An alert, non-critically ill inpatient with a diabetic foot infection has fasting blood glucose levels consistently between 145–160 mg/dL. What is the best management approach?

A. Initiate strict fasting protocol
B. Maintain current glucose targets
C. Tighten control to 80–110 mg/dL
D. Relax targets to >200 mg/dL

11. An 80-kg patient with a large, draining diabetic foot ulcer requires nutritional support. What is the estimated daily protein requirement?

A. 40–50 g to spare renal function
B. 200 g for maximum anabolism
C. 150–180 g per standard protocol
D. 100–120 g to meet demands

12. A patient presents with a deep, infected, neuroischemic ulcer. Which referral strategy optimizes limb salvage?

A. Concurrent vascular and infectious consults
B. Treat infection first, then refer to vascular
C. Revascularize first, then treat infection
D. Sequential referral starting with podiatry

13. A diabetic foot ulcer probes to bone. Superficial swab cultures are positive for Staphylococcus aureus. What is the most appropriate next step?

A. Apply topical antimicrobial dressings
B. Schedule follow-up in four weeks
C. Obtain imaging and bone biopsy
D. Treat based on superficial swab results

14. A patient with a diabetic foot ulcer repeatedly misses appointments, citing a lack of transportation. Which action addresses the primary barrier?

A. Intensive patient education
B. Discontinuation from practice
C. Prescription of home health
D. Psychiatry referral for motivation

15. A patient with a diabetic ulcer and Stage 4 chronic kidney disease requires nutritional intervention. How should protein goals be determined?

A. Prescribe standard diabetic renal formula
B. Collaboration with nephrology and dietetics
C. Default to high-protein wound protocols
D. Strict protein restriction to 0.6 g/kg

16. A patient with a diabetic foot ulcer presents with extending cellulitis, fever of 38.9°C (102°F), and tachycardia. What is the correct triage decision?

A. Outpatient intramuscular antibiotics
B. Next-day follow-up in the clinic
C. Oral antibiotics with daily monitoring
D. Immediate emergency department referral

17. For an 84-year-old patient with a diabetic ulcer, history of falls, and cognitive impairment, what is the primary glycemic management goal?

A. Avoidance of hypoglycemia
B. Strict normalization of HbA1c
C. Maintenance of HbA1c < 6.5%
D. Aggressive insulin therapy

18. A patient with a non-healing ulcer has monophasic pulses and an ABI of 0.6. What is the specific role of the vascular surgeon in this case?

A. Oversee antibiotic management
B. Apply total contact casting
C. Perform revascularization
D. Manage local wound debridement

19. In the physiological sequence of diabetic wound healing, which phase is most characteristically prolonged and fails to progress?

A. Proliferative phase
B. Remodeling phase
C. Hemostasis phase
D. Maturation phase

20. Which complication of autonomic neuropathy most directly predisposes the diabetic foot to bacterial invasion and infection?

A. Neuropathic edema
B. Cutaneous anhidrosis
C. Charcot neuroarthropathy
D. Motor neuropathy

21. A clinician debrides a plantar diabetic foot ulcer but fails to implement an offloading plan. What is the likely clinical outcome?

A. Rapid ulcer expansion
B. Excessive granulation
C. Systemic bacteremia
D. Recalcitrant healing

22. Which physiological process is the primary hallmark of the remodeling phase of wound healing?

A. Collagen Type I synthesis
B. Rapid capillary angiogenesis
C. Granulation tissue formation
D. Neutrophil infiltration

23. A diabetic patient with a non-healing foot ulcer has an Ankle-Brachial Index (ABI) of 1.4. Which test is indicated next?

A. Computed Tomography Angiogram
B. Magnetic Resonance Imaging
C. Toe-Brachial Index (TBI)
D. Repeat Ankle-Brachial Index

24. A patient demonstrates loss of vibratory sensation and proprioception. Which clinical risk is primarily associated with this large-fiber deficit?

A. Severe burning paresthesia
B. Temperature hypersensitivity
C. Autonomic sudomotor dysfunction
D. Small fiber nerve degeneration

25. A diabetic patient presents with a red, hot, swollen foot but no open wound or systemic fever. What is the priority intervention?

A. Topical antifungal medication
B. Strict total non-weight bearing
C. Intravenous antibiotic therapy
D. Surgical debridement of bone

26. Which growth factor is critically deficient in diabetic wounds, directly leading to impaired angiogenesis and capillary sprouting?

A. TNF-alpha
B. Interleukin-1
C. Fibrinogen
D. VEGF

27. How does the accumulation of advanced glycation end-products (AGEs) structurally alter the skin in patients with diabetes?

A. Decreases collagen turnover
B. Increases tissue flexibility
C. Enhances capillary perfusion
D. Accelerates re-epithelialization

28. A patient perceives a sharp pinprick but cannot feel the 10g Semmes-Weinstein monofilament. What is the correct interpretation?

A. Normal somatosensory function
B. Hyperesthesia to pressure
C. Loss of protective sensation
D. Intact protective sensation

29. What cellular dysfunction primarily drives the transition of a diabetic foot ulcer into a chronic, non-healing state?

A. Senescence of dermal fibroblasts and keratinocytes
B. Excess tissue inhibitors of metalloproteinases
C. Premature endothelial progenitor differentiation
D. Systemic depletion of circulating neutrophils

30. A diabetic patient has palpable pulses, normal ABI, but a non-healing ulcer and atrophy. Which pathology is indicated?

A. Systemic inflammatory response syndrome
B. Microvascular disease (microangiopathy)
C. Significant proximal arterial occlusion
D. Deep venous thrombosis with reflux

Answer Key & Explanations

1. D — Simplify regimen and order home health services
Simplifying treatment and ordering home health supervision ensures adherence in patients with cognitive impairment and limited support.

2. A — Redirect to local outpatient wound care clinic
Low-risk, stable chronic wounds should be managed in community outpatient settings to prevent resource mismanagement at tertiary centers.

3. C — Serum prealbumin level of 12 mg/dL
Prealbumin is a sensitive indicator of recent protein status; levels below 15 mg/dL suggest malnutrition despite obesity.

4. A — Increased patient referral volume
The primary measure of success for a multidisciplinary team is the reduction of major amputations through coordinated intervention.

5. B — Proactively increase insulin therapy dosage
Corticosteroids cause significant insulin resistance; management must include proactively increasing insulin to prevent hyperglycemia and impaired healing.

6. D — Case management and social work
Psychosocial factors cause recurrence; refer to case management and social work.

7. A — A to vascular clinic; B to emergency
A to vascular clinic; B to emergency for suspected gas gangrene and sepsis.

8. C — Approximately 2400 to 2800 kcal per day
Use 30–35 kcal/kg: 80 kg × 30–35 = 2400–2800 kcal/day.

9. A — Routine wound care follow-up
ABI 0.45 indicates severe ischemia; urgent vascular referral required.

10. B — Maintain current glucose targets
Target glucose 140–180 mg/dL in noncritically ill inpatients to reduce hypoglycemia risk.

11. D — 100–120 g to meet demands
Catabolic wounds require 1.25–1.5 g/kg/day. For 80 kg, this equals 100–120 g daily.

12. A — Concurrent vascular and infectious consults
Simultaneous care addresses ischemia and infection in parallel, preventing delays inherent in sequential referrals.

13. C — Obtain imaging and bone biopsy
Positive probe-to-bone suggests osteomyelitis. Superficial swabs are unreliable; imaging and bone biopsy

confirm diagnosis.

14. A — Intensive patient education
The barrier is structural (transportation). Social work assists with logistical resources to resolve this.

15. B — Collaboration with nephrology and dietetics
Balancing CKD protein restrictions with wound healing requirements necessitates multidisciplinary collaboration.

16. D — Immediate emergency department referral
Fever and tachycardia indicate severe infection requiring immediate inpatient management; outpatient referral is unsafe.

17. A — Avoidance of hypoglycemia
In frail elderly patients, hypoglycemia risks outweigh tight control benefits; prioritizing safety is essential.

18. C — Perform revascularization
The vascular surgeon's primary role is assessing for and performing revascularization to restore pulsatile flow.

19. A — Proliferative phase
Chronic hyperglycemia arrests wounds in the inflammatory phase, preventing progression to proliferation and remodeling.

20. B — Cutaneous anhidrosis
Anhidrosis causes dry, cracked skin, creating portals for bacterial entry and increasing infection risk.

21. D — Recalcitrant healing
Without offloading to relieve mechanical stress, the wound stimulus persists, leading to recalcitrant healing.

22. A — Collagen Type I synthesis
Remodeling replaces immature Type III collagen with Type I collagen to increase wound tensile strength.

23. C — Toe-Brachial Index (TBI)
An ABI > 1.4 indicates calcified arteries; TBI is reliable as toe vessels rarely calcify.

24. A — Severe burning paresthesia
Large-fiber neuropathy causes loss of protective sensation, leading to unperceived repetitive trauma and subsequent ulceration during ambulation.

25. B — Strict total non-weight bearing
These signs suggest acute Charcot neuroarthropathy. Immediate total non-weight bearing prevents bone collapse and permanent foot deformity.

26. D — VEGF
VEGF drives angiogenesis. In diabetic wounds, blunted VEGF expression leads to poor capillary growth and insufficient granulation tissue.

27. A — Decreases collagen turnover
AGEs cross-link collagen, making it resistant to enzymatic degradation. This reduces collagen turnover, causing stiff, non-compliant skin.

28. C — Loss of protective sensation
Inability to feel the 10g monofilament indicates loss of protective sensation, reflecting large-fiber dysfunction.

29. A — Senescence of dermal fibroblasts and keratinocytes
Persistent pro-inflammatory M1 macrophages prevent transition to the proliferative repair phase.

30. B — Microvascular disease (microangiopathy)
Atrophic skin and poor healing with normal macrovascular exams suggest capillary-level microangiopathy.

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