necrosis appears) or clinical signs of infection worsen, conservative surgery should be consider.

Conservative surgery consisting of removal of the infected bone without performing amputation of any part of the foot and has provided very good results in patients well vascularized, even when bone infection is accompanied by so tissue infection, with 100% of limb salvage rates [10].

In my opinion osteomyelitis is debated still today due to various causes: the rst and most obvious is the absence of evidence to the best option of treatment: antibiotics versus surgery. e second reason is the heterogeneity of health care settings where the diabetic foot is being treated. In some units lacking of surgeon specialized in diabetic foot surgery or in the other hand, lacking of internal medicine doctors specialised in diabetic foot infections, the rst treatment is always the option in which team members are better trained. If patient is being treated by diabetic foot's surgeon probably surgery it will be the rst option instead when bone infection is treated in the absence of surgeons, probably it will try to resolve it by antibiotic treatment.

Furthermore, in a non-specialized diabetic foot unit, usually there is a misconception from osteomyelitis. Most professionals understand diabetic foot osteomyelitis infection equal, but it is not. e heterogeneity of clinical presentation, and dissemination of their involvement in bone tissue coupled with the diversity in the in ammatory response of patients with the presence of some degree of peripheral vascular disease, are making hard to treat this complication with just one treatments' option. Not every patient needs to be treated di erently, but treating all alike is not the most desirable option.

De nitely strati cation or classi cation of diabetic foot osteomyelitis attending general and local criteria, could establish a standard protocol that could respond to most cases. Meanwhile further research is the only way to improve the care of our patients with diabetic foot.

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