Abstract

The Charcot neuroarthropathy is a progressive degenerative disease which affects the foot joints, and diabetes is its main cause. This neuroarthropathy is one of the most serious complications in diabetes mellitus, because it induces important deformations in the toe and foot with big disability in the patient.

The scientific evidence shows that those patients must keep a strict control in their blood glucose levels. Other studies have reported that most of them had a previous history of problems in feet, along with a loss of feeling of protection. To avoid "disasters" that end with an amputation of the limb, patients must be teaches about foot care and favoring the training of skilled nursing professionals on diabetic foot.

It is primordial to always keep in mind that the sooner this asthropathy is diagnosed, the sooner most complications can be avoided in the medium and long term. The creation of diabetic foot units favors the early diagnosis and this means a bigger economic saving and a bigger quality of life for the patients and their families, it also means a place where patients can be sended in case they don’t evolve properly in nursing consultation. Giving the importance diabetic foot has among professionals and diabetic patients is a pending subject in a lot of cases. Listening to the patient and their family is a fundamental step of the process which is forgotten in lots of cases.

INTRODUCTION

The diabetes mellitus and the peripheral neuropathy are the main risk factors of the neuroarthropathy in the foot and the toe. The diabetic polyneuropathy is the most common cause of the neuropathic osteoarthropathy in the developed countries. This neuroarthropathy is one of the most serious complications in diabetes mellitus, because it induces important deformations in the toe and foot with big disability in the patient [1-3].

The Charcot neuroarthropathy is a progressive degenerative disease which affects the foot joints, and diabetes is its main cause. It is characterized by a progressive destruction of the bones that bear weight and the joints, which leads to a bigger instability, ulcerations and/ or recurrent amputations [4].

Jean Marie Charcot, in 1868 described the Charcot foot in patients with dorsal tables as a quick and unfavorable evolution, deterioration and joints instability. In 1936 Jordan affiliated the diabetes mellitus to neuropathic changes in the foot and the toe [5,6].

One of the theories that try to explain the changes that happen in the Charcot arthropathy is the neurovascular theory. This theory refers to the rise of the peripheral blood flow of the foot bones being this the responsible of the bone reabsorption, demineralization and osteopenia that are found in this pathology.

The Charcot arthropathy reduces the quality of life of patients and leads to a motor disability, loss of limbs, early retirement, and death.

To avoid the complications of this arthropathy is essential to keep a strict control of patients with high risk diabetes and to recognize the first signs of Charcot arthropathy. To people with diabetes you have to educate them in the right self-care and daily feet inspection and in the glycemia control [7-10].

MATERIALS AND METHODS

Description of a clinical case that was shown in a meeting of skilled diabetic foot and that since that moment a tracing was made in our consultation. Woman, 69 years old, arterial hypertension, obesity (IMC 39,12), hypothyroidism, dyslipidemia, diabetes mellitus type 2 for 14 years, insulinized 2 years ago, diabetic retinopathy, Charcot arthropathy in the right foot, polyarthritis and exhumation for 20 years.

Biochemical parameters: HbAcl: 7.7%, the rest is within normality.

RESULTS AND DISCUSSION

Disaster nº1

This patient had never subjected to no diabetic foot revision.
in 14 years, neither in primary care, nor in specialized, i.e., in no
type of care.

The “Clinical Guides” recommend to check the feet of every
patient with diabetes at least once a year and to establish the risk
of ulcers. Prevention, since Primary Care by identifying the “high
risk” patients, represents the most effective way to reduce the
ulcer formation and the number of amputations on those patients.

According to the recommendations of the International
Working Group on Diabetic Foot [IWGDF 2015], the basic
exploration should include a search of signs and symptoms
of sensory neuropathy, peripheral arterial disease and foot
deformations.

**Disaster nº2**

When the evolution of her astropatia started nobody
recommended her to go to a specialist in podiatry to put the
appropriate discharges [11-15].

It is necessary to make a clinical assessment to the patient
and to adjust their clinical necessities to technical possibilities,
evaluating in each case different aspects (neuropathy, range
of joint mobility, deformities, partial amputations).

**Disaster nº3**

Ulcer cure by a non-expert staff Figure 1. In November 2014
they blew her a blister in the foot in the urgency service, closing
in false and the ulcer and the aspect of the foot in general were
worsening. The families attend to different public and private
centres, but without expert staff in diabetic foot, looking for the
cure. This has given them a total economic outlay of 30,946 euros
and a year of their time. In our city there is no diabetic foot unit
[16-18].

The patient is derived from a hospital to a primary care
consultation that owns a nursing professional who is an expert
in the field. Begins to heal with discharges of felt and the ulcer
improves Figure 2.

**Disaster nº4**

The patient attends to a trauma consultation to value
her Charcot arthropathy and on that, the Traumatologist
recommends as a treatment putting the foot to soak with water.
The wound got worst and ended with two cracks of 1´7 and 1´2
cm in length. Since 2 months ago we have resumed the cure in
primary care, she has been referred to a specialized podiatry
center to the realization of discharge templates in both feet and
the use of suitable footwear and in this moment she is really close
to a healing Figure 3.

**CONCLUSION**

The scientific evidence shows that those patients must keep
a strict control in their blood glucose levels. Other studies have
reported that most of them had a previous history of problems
in feet, along with a loss of feeling of protection, hence the
importance of diabetic foot units with multidisciplinary teams
that favor the diagnosis, the prevention and the treatment in
diabetic patients including in being teaches about the feet self
care.

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**Figure 1** Ulcer cure by a non-expert staff.

**Figure 2** Healing with discharges of felt and the ulcer improves.

**Figure 3** Close to a healing.

It is primordial to always keep in mind that the sooner this
arthropathy is diagnosed, the sooner most complications can be
avoided in the medium and long term. The training of nursing
professionals’ experts in diabetic foot and the creation of diabetic
foot units favors the early diagnosis and the treatment and this
means a bigger economic saving and a bigger quality of life for
the patients and their families, to get there, the patient and their
relatives must be taught to work with their emotions [19-22].
Giving the importance diabetic foot has among professionals and
diabetic patients is a pending subject in a lot of cases. We would
like to expose the “Family thoughts”, main part of the process and
in most cases forgotten:

Trying to achieve a contact person specialized in diabetic
foot, above all a nurse for the cure and having them as a reference,
for any anomalous sign. Template guidelines, foot support... to
whom to turn.
Recommended follow-up time between visit and visit, how to coordinate specialists and to see who is able to take command of the problem, a coordinator is needed. Searching for diabetic foot unit somehow. Is there any solution for the real problem? Or just extreme prevention and vigilance? Can only pallia not cure?

REFERENCES

9. Charcot JM. On some arthropathies, which seem to depend on a lesion of the brain or of the umbilicus? Arch Physiol Norm Pathol. 1868; 1: 161-78.