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Factors Predicting Recurrence of Diabetic Foot under Hallucinogen

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Abstract

A prospective study conducted from January 2012 to December 2014 was performed in a diabetes treatment unit to assess risk factors associated with relapse of hallucinations. Sixty patients with diabetic neuropathy and a history of ulcers were included continuously. Sociopathological factors and comorbidities as well as biomechanical and radiological factors were obtained. Participants were followed up monthly, and they wore load-reducing therapy shoes and custom insoles. Hallux recurrence during follow-up was evaluated as the primary endpoint of the study. Patients were followed for 29 (14.2-64.4) months. 29 patients (52%) with new ulcers: 9 patients (31%) in the hall and 20 (69%) in other locations. Are functional hallucinations limit (, 95% CI (2,097-73,128), HR 12,384) and increased body mass index (, 95% CI (1,003-1,272), HR 1.129) related to survival time hallucinogenic ulceration in a multivariable Cox model. Obesity and the presence of functional hallucination limitation increase the likelihood of developing recurrent hallucinations in patients with diabetic neuropathy and a history of ulcers.

Keywords: Ulcer; Hallux; Diabetic neuropathy

Introduction

Recently, the prevalence of foot ulcers in people with diabetes has been estimated to be between 19% and 34%. At least 85% of lower limb amputations are caused by diabetic foot ulcers (DUP), which significantly increases the economic costs of health care and reduces life expectancy. Primary prevention of DFU becomes important, as mortality within the first year after the first diagnosis of DFU has been reported in 12% of patients. Diabetic neuropathy, pre-ulcerative lesions, peripheral artery disease, foot deformity, and plantar fascia have been identified as major risk factors for DFU. Forty percent of patients will experience a relapse within a year of ulcer healing. The initial triggers that lead to the ulcer usually do not resolve after healing. The forefoot is the area with the highest rate of DFU. In particular, hallux accounted for one-third of the total areas affected by DFU. Recurrent hallux can lead to amputation, which has devastating effects on the biomechanics of the foot and increases the risk of new ulcers and lower limb amputation [1-3]. Research into risk factors for recurrent hallucinogens may lead to a reduced incidence of ulcers and help avoid the need for resection of hallucinogen syndrome and its devastating consequences.

Normal range of motion (ROM) of the first metatarsal joint (first MTPJ) is defined as dorsal flexion greater than 65°, whereas flexion of the toes is a severe limitation of dorsal flexion (<30°). The amplitude of the first MTPJ was systematically evaluated at the unsupported site in diabetic patients at high risk of ulceration. However, mobility of the first MTPJ at rest is considered to be a poor predictor of abnormal first-ray function in gait. Examination of the foot in an unsupported position may be normal, but dorsal flexion of the first MTPJ may be blocked with walking, which means that this risk factor may remain undetected. This condition in which range of motion is reduced when the forefoot is loaded is known as functional hall limitation. To evaluate the limited mobility of the MTPJ first related to the location of the ulcer in the corridor, but they could not find any association. reported a relationship between hallucinogenic ulcers and a group of malformations including limited mobility of the first MTPJ. These studies evaluated the factors associated with lobar ulceration in diabetic patients and measured the range of motion of the first MTPJ at rest [4-7]. These authors demonstrated that almost all patients had limited first-line MTPJ locomotion and that nearly half of the patients had limited functional hallucinations. A higher rate of limited movement of the first MTPJ has been reported in patients with a history of hallucinogenic ulcers; however, to date, the link between hallucinogenic reconstruction and limited mobility in the first MTPJ has not been explored through a prospective follow-up study. The objective of our study was to evaluate the predictors of subnormal recurrence in individuals with a history of diabetic foot ulcers.

Biomechanical assessment

Foot type was classified using the validated Foot Posture Index (FPI-6) protocol. A total FPI-6 score between 0 and +5 indicates a neutral foot, a score greater than +6 indicates a strong pronation or supine foot, and a score between -1 and -12 indicates a strongly supine or supine foot. Hallux malformation is considered when Hallux has one of the following: hallux valgus, protrusion at the tip of the first metatarsal, or hammer toe deformity of hallux. Range of motion of the following joints is measured with a bi-arm voltmeter: ankle joint, subtalar joint and first MTPJ [8]. Ankle dorsal flexion is examined with the patient in the supine position, keeping the subtalar joint in a neutral position while performing forced dorsal flexion at the ankle joint and measuring the angle formed between the faces. cut of the fibula and lateral foot, this angle was previously marked in the patient. The ROM of the subtalar joint is examined with the patient in the prone position and holding the calcaneus with one hand and the head/talar neck with the thumb and index finger of the other hand. The referral and abduction ROMs were evaluated manually on calcaneus. Finally, the degree of dorsal flexion of the first MTPJ was recorded with the patient sitting in the resting position and the patient standing in the standing position. The center of the potentiometer is placed in the center of the tip of the colon [9]. The proximal arm is placed parallel to the ground and the foot on the ground is held firmly with one hand. The distal

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or mobile arm is placed parallel to the profile of the proximal knuckle to avoid the influence of the ROM interphalangeal joint and the other hand is held to the toe. The maximum passive backbend range has been recorded [10].

Discussion

The outcomes of this study demonstrate that the presence of functional hallucination limits increases the likelihood of recurrent hallucinations in patients with a history of diabetic foot ulcers. The ROM of the first MTPJ is a determinant for the phantom pressure during mid- and thrust, and it is also considered a possible cause of phantom ulceration. However, to date, this relationship has not been demonstrated in prospectively monitored diabetic patients. One of the difficulties in the debate about the range of motion limitation of the first MTPJ is the inconsistency found in the literature regarding joint measurement. He evaluated resting hallux ROM in 60 patients with a history of leg ulcers and found no difference in ROM between the hallux ulcer group and the control ulcer group. In our study, no association was found with recurrent hallucinations when the hallucinogenic dorsal flexion response was assessed in the unsupported position. High prevalence of limited ROM of the first MTPJ and limited functional virtualization in patients with a history of hallucinogenic ulcers. However, they did not consider a control group and therefore the statistical association was not investigated. In addition, follow-up of patients with a history of hallucinogenic ulcers was not performed. The functional Hallux limit state biomechanical theories suggest that elevating the head of the first metatarsal and increasing tension in the plantar fascia may alter joint dynamics in the first MTPJ. Due to ground reaction forces acting on the head of the first metatarsal during the mid and thrust phases, first ray dorsal flexion occurs in some patients, which may lead to MTPJ obstruction. the first. In our radiographic univariate analysis, an increase in dorsal flexion of the metatarsal was first observed in patients who had previously developed recurrent hallucinations, which would support this theory. Evaluation of dorsal flexion of the metatarsal in the standing position did not reproduce evidence of weight carried by the head of the first metatarsal, and the outcomes were normal even though dorsal flexion of the joint was prevented.

Conclusion

Cumulative tissue stress has been shown to affect recurrence rates in the foot and is the outcome of a combination of plantar pressure and walking activity. However, no variables were evaluated in this study. Second, patient compliance was not assessed in this study; the authors encouraged patients at each monthly visit to use therapeutic shoes, and all participants reported using prevention strategies. However, objective compliance assessment methods should be used in further studies.

Conflict of Interest

None

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