

Letter to the Editor

Comments on "Prevalence and risk factors of Diabetic Foot changes among Community-Dwelling Adults with diabetes mellitus in an Underprivileged Area of Bangalore: A Cross-Sectional Study"

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The Letter to the Editor responds to Sridhar et al.'s study (Acad Med Surg, 2025) reporting a 62.6% prevalence of diabetic foot changes among adults with diabetes in Tavarekere slum, Bangalore. The study highlights a critical public health issue in underprivileged communities, identifying dry skin, cracks, and older age as significant risk factors. We commend the authors for addressing this gap but suggest further exploration of cultural practices, such as barefoot walking, which increases foot injury risk. To enhance implementation of the study's call for routine foot examinations, we propose training community health workers for cost-effective screenings and education, supported by evidence from community-based interventions in India. Integrating these strategies into national diabetes programs could improve scalability and reduce complications. Future research should evaluate subsidized footwear and community-level interventions to mitigate diabetic foot morbidity, enhancing quality of life in resource-limited settings.

To the Editor,

We read with interest the article by Sridhar et al., published in the May 5, 2025, issue of *Academic Medicine & Surgery*, which reports a 62.6% prevalence of diabetic foot changes among adults with diabetes in Tavarekere slum, Bangalore.¹ The study's focus on an underprivileged urban population addresses a critical gap in community-based research on diabetic foot complications, a significant global health issue contributing to morbidity and amputations.² The authors' emphasis on dry skin (48.1%) and cracks (41.9%) as prevalent pre-ulcerative conditions underscores the need for early intervention to prevent progression to ulcers.

The finding that older age (≥ 45 years) is a significant risk factor (AOR: 1.94, $p = 0.02$) aligns with literature on age-related vulnerabilities, such as reduced skin elasticity and neuropathy-induced sensory loss. However, we suggest further exploration of cultural practices, such as barefoot walking, noted as common in underprivileged areas. A 2007 study identified barefoot walking as a risk factor for diabetic foot injuries in developing countries, increasing trauma and infection risk.³ Qualitative data on such behaviors could identify barriers to adopting protective footwear.

The study's call for routine foot examinations is commendable, but implementation in resource-limited settings

requires practical strategies. Training community health workers to perform basic foot screenings and educate patients on self-care could be cost-effective. A 2019 study in Bengaluru demonstrated that community-based education improved foot care practices among diabetic patients.⁴ Similarly, a 2021 trial showed that community health worker-led interventions reduced diabetic foot ulcer incidence by enhancing early detection.⁵ Integrating such interventions into programs like India's National Programme for Prevention and Control of Diabetes could enhance scalability.

We applaud the authors for highlighting the urgent need for multidisciplinary approaches to diabetic foot care. Future research should evaluate subsidized footwear programs and community-level interventions to reduce complications, ultimately improving quality of life in vulnerable populations.

Sincerely,
Mohammad Idrees, Anfal Khan, Dr Amin UL Haq

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