

“Recurring Foot Ulcers”, Causes, Diagnosis and Management Challenges

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Abstract

A recurrent neurochemical foot ulcer is an open skin sore that keeps coming back because of both nerve damage Nerve damage (neuropathy) as the patient cannot feel pain, heat, or pressure, so small injuries go unnoticed and due to poor blood flow (ischemia), reduced oxygen and blood supply prevent the wound from healing properly. Walking puts repeated stress on the same weak spot on the foot. Bacteria easily enter the broken skin and cause deeper tissue damage.

The primary determinants of recurrent foot ulcers are diabetic foot ulcers (DFUs) due to uncorrected mechanical pressure, nerve damage, and poor blood flow. Recurrence rates are exceptionally high, up to 40% within one year and 65% within five years of initial healing. Non-diabetic foot and chronic lower extremity ulcers in India are primarily driven by trauma, venous insufficiency, and peripheral vascular disease rather than glycemic complications. Roughly 40% of non-diabetic venous or traumatic chronic wound patients experience recurrence, largely driven by inadequate compression therapy, delayed treatment, and lack of patient's compliance of foot care.

Key Steps for Treatment include i) Take all weight off the foot using a special cast, boot, or crutches so the skin can close ii) Consulting a vascular specialist for procedures to open blocked arteries and improve circulation to the foot as a restoring blood flow strategy iii) Keep the wound clean, moist, and free of dead tissue by periodical debridement.

Materials and Methods: This article is based 2 different aetiology cases of recurrent foot ulcers, managed by this author, with required consultation of specialist as and when required one of non-diabetic chronic lower extremity ulcers and another diabetic recurrent foot between 2023 and 2026, causes, challenges and management at home. The author compares the key features of these two types of foot ulcers. Key management strategies remain similar except in diabetic foot ulcer, managing Blood sugar levels hold key solution.

Outcomes: Our diabetic foot ulcer case has fully recovered with Blood sugar well maintained and able to walk on his own, the non-diabetic foot ulcer case has had 3 episodes, each time ulcer healing in 4-6 weeks' time, thanks to antibiotic therapy & debridement.

Key Words: DST= Digital subtraction angiography

Introduction

Foot ulcers in India are most commonly caused by diabetic neuropathy, peripheral arterial disease, and venous insufficiency, with diabetic foot ulcers (DFUs) affecting up to 15% of individuals with diabetes in the country [1] Diabetic foot ulcers (DFUs) in India recur more frequently, present with deeper tissue damage, and carry a significantly higher risk of lower-limb amputation compared to non-diabetic recurrent foot ulcers [1,2].

Key Clinical Differences are: a) Peripheral neuropathy is drastically higher in diabetic patients b) Diabetic recurrent ulcers more frequently present as advanced lesions such as Wagner's grade 4 compared to milder or more superficial grades common in non-diabetic cohorts, Recurrent ulcers in diabetics frequently form on the dorsum (top) or plantar pressure points of

the foot due to deformities, whereas non-diabetic recurrent ulcers often localize to the toes due to localized trauma or footwear friction, The rate of major and minor amputations is notably higher in recurrent diabetic foot ulcers, and a prior amputation sharply multiplies the risk of subsequent contralateral or ipsilateral amputations over time [2,3].

Pathophysiology: Recurrent Foot ulcers in individuals develop from neuropathy, ischemia, or a combination of both. They are classified as ischemic, neuropathic, or neuro ischemic. 1. Neuropathic Ulcers: Make up most cases (around 73%) and typically present with a better overall healing trajectory over time when properly offloaded, though they carry high recurrence risks due to lack of protective sensation. 2. Ischemic (and Neuro-ischemic) Ulcers: Ischemic diabetic foot ulcers occur due to poor blood flow as narrowed arteries combined with diabetes to break down skin and tissue

on the foot. They present with reduced arterial perfusion, larger initial surface areas, and higher pain or tissue necrosis levels and respond poorly to standard local care alone & demonstrate significantly lower healing rates without vascular intervention. Ischemic diabetic foot ulcers carry a higher risk of non-healing & worse outcomes compared to neuropathic ulcers due to compromised blood flow, advanced tissue damage, and higher rates of severe infection [2,3,4].

Diagnosis is based on Physical exam which includes checking foot pulses, observe skin colour, temperature, and look for painful or necrotic (dead tissue) irregular lesions. Comparing blood pressure in the ankle and arm to calculate Ankle-brachial index (ABI) will detect blood flow blockages Doppler ultrasound, CT angiography, or MR angiography visualize narrowed arteries. A doppler test is most effective at explaining early physical signs like intermittent claudication. An extensive arterial blockage mapping by DSA is the gold standard for diagnosis for non-diabetic foot ulcers [2,4].

Management and Treatment: Current treatment practices of foot ulcers include a) Regular debridement removes dead or infected tissue to create a clean, moist healing environment, b) Offloading weight: Special healing shoes, boots, or total contact casts relieve pressure from the wound area and facilitate the skin to close c) Infection control: Systemic antibiotics treatment based on Culture and sensitivity testing of discharges at the wound d) Strict blood sugar management to support tissue repair and stops infection growth e) Minimally invasive procedures like angioplasty, stenting, or endovascular revascularization to open blocked arteries to improve circulation are considered for recurrent foot ulcers [5].

This article is based 2 different aetiology cases of recurrent foot ulcers, one of non-diabetic chronic lower extremity ulcers and another diabetic recurrent foot between 2023 and 2026, causes, challenges and management at home.

Case Report 1: Non-diabetic Foot Ulcers: Mr. Anil a Textile engineer complained about the first time in Mid -July 2023, Burning in 2nd and 3rd toes tips of right leg intermittently. The local surgeon suspected ischaemic limb and put him on Stiloz 100 mg tablets along with a blood thinner and Aspirin. Stiloz contains Cilostazol an oral prescription medication used to improve the symptoms of a circulation problem in the legs called intermittent claudication. Soon the 2nd toe got infected, locally managed in Gunavati a town, in Karnataka, with antibiotics and dressing did not heal for over 2 months. and Surgeon amputated the toes in early 2024. In mid-July 2025 he had similar ulcer on right little toe, again managed locally for about 3 weeks. Then we consulted a vascular surgeon, in a private tertiary care hospital in Bengaluru. After debridement, culture sensitivity-based antibiotic (the culture of the sound swab showed growth of *Pseudomonas Areosa*) was given for 2 weeks. And the toe healed only by December 2025. Currently he has his right 2nd toe infected and advised debridement and antibiotic therapy (Fig.3). A doppler Test was done on 11 August 2026 which showed everything to be normal. Given the limitation of Doppler test, which identifies only when the narrowing or blockage is 50% or more, Neuro-ischaemic ulcer cannot be ruled out. On 30 August his Hb1Ac was 5.8%, FBS=76 mg/dl and PPBS= 102 mg/dl and Mean BS=126.5mg/dl, ruling out the diabetic origin. Due to poor blood flow (ischemia), reduced oxygen and blood supply prevent the wound from healing properly. Walking puts repeated stress on the same weak spot on the foot. Bacteria easily enter the broken skin and cause deeper tissue damage over time. Currently he is on Standard management of surgical debridement of necrotic tissue, and culture-directed antibiotic therapy for active infections.



Case Report 2. Diabetic Recurrent Foot Ulcer Conservative

Management at home: Mr. Padki aged about 72 years in June 2023 hurt his right foot, that was not well attended, and infection set in in about a week's time. A consultation in a nearby surgical nursing home, debridement and dressings, IV antibiotics and a week's hospital stay. The dressings everyday involved an expense of INR 1000 (including commuting). Two weeks after discharge, the wound got reinfected and another course of antibiotics didn't help. The surgeon suggested below knee amputation of limb. They consulted this author in Mid-July 2023. After visiting the patient at their home, attempting debridement myself, was easy as the entire foot was painless with good vascularity. In the first visit discussing the complexity and burden of coordinating with external caretakers and medical personnel, including arranging transport to and attending follow-up medical appointments, challenges of frequent changes to home care nursing staff. I suggested involvement of his spouse and son was better for doing dressing and doing most of the care. Both agreed in principle. I explained to them the elements of ulcer care in the home, changing of wound dressing, application of topical ointments, and cleaning and elevation of the wounded leg. I told them that the healing of ulcers depended on keeping the wound clean, using the Betadine lotion and demonstrated using scissors & a toothed forceps to

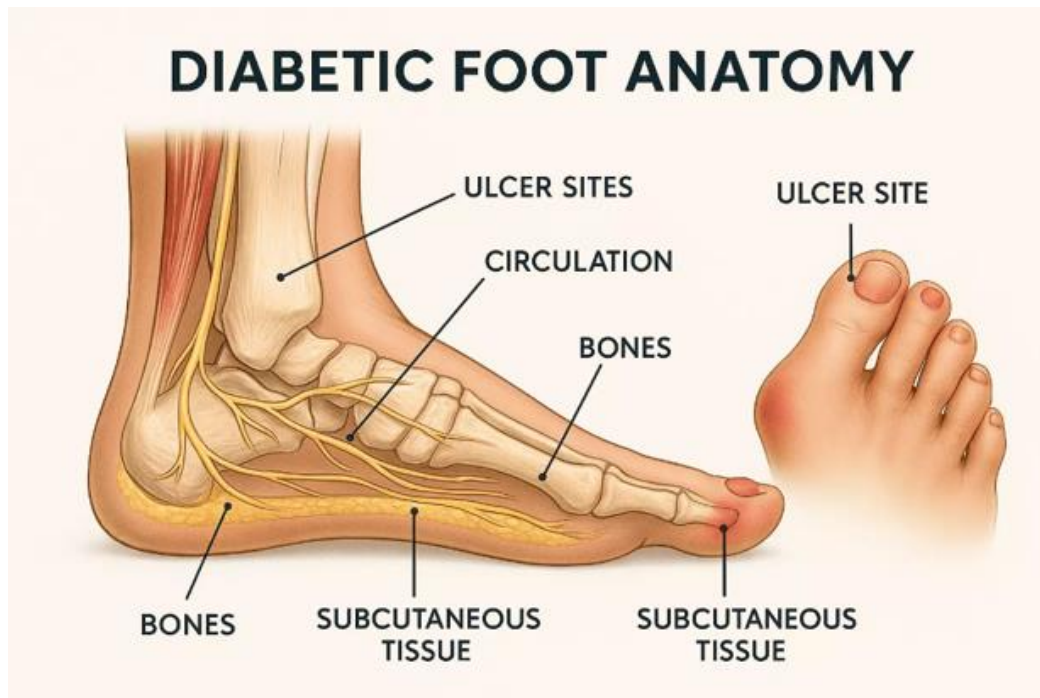
debride what was dying off and to allow new tissue to grow for 6-8 months. One of them did alternate day dressings initially for about a month and twice a week subsequently for 2 months. Patient's son and wife agreed and did without fail the care responsibility. The required set of scissors, artery forceps and holding toothed forceps, pairs of gloves etc. were bought along with dressings, sterile gauzes, silver ointment, & replenished them periodically. All sitting's expenses were around INR 100 on these items each time. They got pretty good at dressings in about half a dozen assisted and supervised performance by this author. After about two months the wound started showing signs of healing with pink granulations. This of course presented challenges in shifting the balance of household labor division and inverting care-taking roles. For example, his 28-year-old son had had to assume the role of primary health care provider. As wife, Son or daughter-in-law had to grab something to drink or eat for the patient. Patient started feeling guilty and would say "Now I'm dependent on somebody for all the tasks. With the concerted counselling and efforts of the spouse and the son debridement in August, September and November the first sign of granulation tissue was seen in October 2023 and the person started walking with walker first and a stick later by March 2024. As of August 2024 he was able to go for walk on his own.



Discussions

Foot ulcers in India are most caused by diabetic neuropathy, peripheral arterial disease, and venous insufficiency, with diabetic foot ulcers (DFUs) affecting up to 15% of individuals with diabetes in the country [1]. Key Clinical Differences to be assessed and analyzed are: 1. Neuropathy and Sensation: Peripheral neuropathy is drastically higher in diabetic patients (up to 72%) compared to non-diabetic ulcer patients (around 20%), making diabetics repeat-prone due to unnoticed recurrent microtrauma. 2 Severity at Presentation: Diabetic recurrent ulcers more frequently present as advanced lesions such as Wagner's grade 4 (deep abscess or osteomyelitis) compared to milder or more superficial grades common in non-diabetic cohorts as

evidence in our cases too. 3. Anatomical Site: Recurrent ulcers in diabetics frequently form on the dorsum (top) or plantar pressure points of the foot due to deformities, whereas non-diabetic recurrent ulcers often localize to the toes due to localized trauma or footwear friction as observed in our case reports. 4. Microbiology and Infection: Both groups show a high prevalence of Gram-negative bacilli and *Staphylococcus aureus*, but diabetic wounds exhibit higher rates of multidrug resistance and biofilm formation, complicating recurrent treatment cycles. 5. Amputation & Healing Rates: The rate of major and minor amputations is notably higher in recurrent diabetic foot ulcers, and a prior amputation sharply multiplies the risk of subsequent contralateral or ipsilateral amputations over time [2,3].



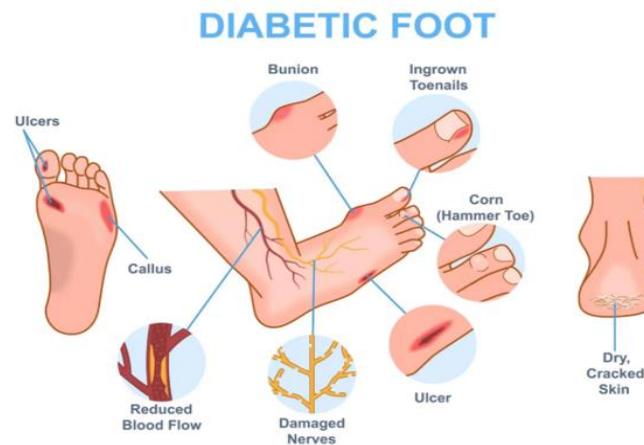
A recurrent Neuro-ischemic foot ulcer is an open skin sore that keeps coming back because of both nerve damage and poor blood circulation in the lower leg. It Keeps Returning due to Nerve damage (neuropathy) as the patient cannot feel pain, heat, or pressure, so small injuries go unnoticed. Due to poor blood flow (ischemia), reduced oxygen and blood supply prevent the wound from healing properly. Walking puts repeated stress on the same weak spot on the foot. Bacteria easily enter the broken skin and cause deeper tissue damage.

Diabetic foot ulcers (DFUs) affect roughly 15% of all people with diabetes in India during their lifetime, with recurrence rates reaching 40% within the first year after initial healing, and 65% within five years of initial healing. The primary determinants of recurrent foot ulcers evolve around uncorrected mechanical pressure, nerve damage, & poor blood flow [1].

Key Risk Factors and determinants include: a) Neurological Factors: Diabetic Peripheral Neuropathy (DPN) a condition in which loss of protective sensation, means patients cannot feel high pressure, rubbing shoes, or minor injuries, allowing trauma to go unnoticed ii) Mechanical and Structural Pressures: A first ulcer located on the sole (plantar side) strongly

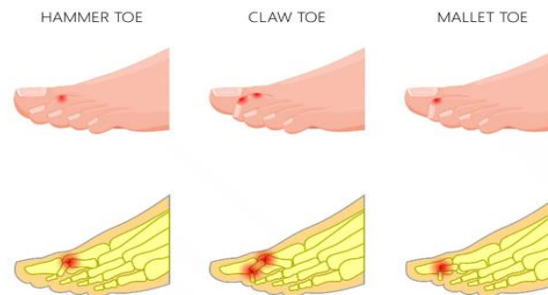
predicts recurrence due to ongoing high vertical and shear stress iii) Foot deformities and prominent Metatarsal Heads with structural issues like hammertoes, bunions, or prominent bone structures create abnormal, localized pressure points iv) Reduced ankle flexibility increases pressure on the forefoot during walking v) Vascular and Systemic Conditions like Peripheral Artery Disease (PAD) lead to poor blood circulation restricting oxygen and nutrients, preventing proper tissue resilience and long-term healing. vii) Poor Glycaemic Control: Persistently elevated HbA1c impairs immune response, white blood cell function, and tissue repair. viii) History of Amputation or Osteomyelitis: Prior bone infection or partial amputation drastically alters foot mechanics and elevates vulnerability in remaining tissues ix) Behavioural and Socioeconomic Influences: Failing to wear specialized therapeutic off-loading footwear post-healing x) Lifestyle and Self-Care Lapses: Skipping daily foot inspections, poor hygiene, or continued smoking xi) Limited financial resources can restrict access to proper follow-up care, specialized shoes, and consistent monitoring [4].

Structural damages of the foot & Toes- Causes, Symptoms, Treatment and Prevention:



Hammer, claw, & mallet toes involve abnormal bending of the interphalangeal joints (IPJ) of the foot are the hinge joints located between the small bones (phalanges) of the toes. Big toe (Hallux) has only one interphalangeal joint because it contains just two phalanges (proximal and

distal). Other toes (2nd to 5th), each has two joints because they contain 3 phalanges i) Proximal interphalangeal (PIP) joint, located between the proximal and middle phalanges ii) Distal interphalangeal (DIP) joint located between the middle & distal phalanges. Each deformity affects different joints & has slightly different causes and management strategies [4,5,9].



Hammer Toes: Bend at the middle joint only at the PIP joint, causing the toe to rise upward and then angle down looking like a hammer.

Claw Toes: Bend upward at the ball of the foot Middle Toe (MTP joint) and downward at both the middle and end joints (PIP and DIP joints), creating a claw-like shape.

Mallet Toes: Bend only at the tip of the toe (DIP joint), causing the end of the toe point downward.

Common reasons for this muscle and tendon imbalance include a) Poorly Fitting Shoes: Shoes with narrow, pointed toe boxes or high heels push your toes forward and cramp them into a bent shape. b) Foot Structure: Having flat feet, high arches, or a second toe that is naturally longer than the big toe can put uneven pressure on the foot c) Genetics: Inherited foot shapes and a family history of toe deformities make you more likely to develop the condition d) Toe Injury: Stubbing, jamming, or breaking a toe can damage the joint and surrounding tissue e) Diseases like arthritis, diabetes, or nerve and spinal cord issues can weaken foot muscles and increase your risk.

Impact of Grade, Stage, and Infection: i) Grade and Depth: Deeper ulcers (such as Wagner grades 3 or higher or those probing to bone/tendon) dramatically increase the risk of chronicity, osteomyelitis, and amputation regardless of aetiology ii) Infection Stage: Moderate to severe infections accelerate tissue destruction and systemic toxicity. Infected ischemic wounds have the highest non-healing and major amputation rates if empirical or mistargeted antibiotic protocols are used without addressing arterial supply.

Key Clinical & Physiological Determinants [6,7]:

Diabetic Peripheral Neuropathy (DPN): The single strongest predictor. Loss of protective sensation means minor injuries or repetitive friction go unnoticed, allowing minor trauma to rapidly degrade into a recurrent ulcer.

Altered Foot Biomechanics & Deformities: Nerve damage leads to muscle atrophy, causing structural shifts like claw toes, bunions, or high plantar pressures. The mechanical stress focused on these specific weight-bearing friction areas makes the sole of the foot exceptionally prone to re-ulceration.

Peripheral Artery Disease (PAD): Poor lower-limb blood circulation drastically hinders wound healing. While historically less prevalent in India than in Western countries, its incidence is rising among Indian patients and severely complicates tissue recovery.

Prior Amputations or Long Ulcer History: A previous minor amputation changes the weight distribution of the foot, tripling the risk of a subsequent ulcer or major amputation. Ulcers originally taking more than 60 days to heal also show a significantly higher rate of recurrence.

Non-diabetic recurrent foot and chronic lower extremity ulcers (NDRFCLEU): Non-diabetic foot and chronic lower extremity ulcers in India are primarily driven by trauma, venous insufficiency, and peripheral vascular disease rather than glycaemic complications. Among them 1 Accidental injury, cuts, or occupational hazards represent the most common cause (up to 45% of non-diabetic chronic leg and foot wounds) 2. Venous Insufficiency: Chronic venous hypertension leads to venous leg ulcers (VLUs) that recur due to improper use or lack of compression stockings 3) Peripheral Arterial Disease (PAD): Poor blood circulation restricts oxygen delivery to tissues, preventing wounds from closing. 4) Infections and

Nutritional Deficiencies: Unmanaged bacterial colonization and poor systemic nutrition delay healing and trigger breakdown [2,9].

Burden of NDRFCLEU in India: Studies show these chronic non-healing ulcers frequently affect older adults, peaking in the sixth decade with a notably higher prevalence in males. Patients often suffer prolonged healing times, with average ulcer durations lasting over a year before definitive care. Roughly 40% of non-diabetic venous or traumatic chronic wound patients experience recurrence, largely driven by inadequate compression therapy, delayed treatment, and lack of patient education. Prolonged morbidity creates high out-of-pocket costs for daily dressings, frequent hospital visits, and lost wages. Management is usually conservative care focussing on daily antiseptic dressings, targeted antibiotic therapy based on wound cultures, and nutritional optimization. Essential for venous ulcers to manage underlying venous hypertension and prevent recurrence is compression therapy. NDRFCLEUs usually require surgical debridement of dead tissue, wide local excision, and skin grafting for recalcitrant wounds. Addressing arterial blockages via revascularization or specialized vascular interventions when blood flow is compromised [2,9].

Treatment Protocols:

- **Key Steps for Treatment Offloading:** Take all weight off the foot using a special cast, boot, or crutches so the skin can close.
- **Restoring blood flow:** Vascular Surgeons can suggest procedures to open blocked arteries and improve circulation to the foot.
- **Wound care:** Keep the wound clean, moist, and free of dead tissue. Specialized dressings are the primary, cost-effective standard for routine wound care in India, whereas hyperbaric oxygen therapy (HBOT) is a high-end adjunctive treatment reserved for severe, non-healing chronic wounds [3,9].

Specialized Dressings: Advanced medical materials like hydrocolloids, alginates, and collagen sheets that keep wounds moist and protected. Cost: Much lower and more affordable for daily or regular outpatient use compared to device-heavy therapies. Availability: Widely available across local clinics, pharmacies, and major hospitals throughout India. Best for: Standard surgical cuts, mild burns, and early-stage pressure or diabetic sores.

Hyperbaric Oxygen Therapy (HBOT): A medical treatment where patients breathe pure oxygen inside a pressurized chamber to boost tissue healing. Cost: Individual sessions and treatment courses range from ₹50,000 to ₹1,00,000, while hospital-grade chambers cost ₹40 lakh to over ₹1.5 crore. Limited to specialized multi-specialty hospitals & advanced wound-care centres in major cities would have it. It is recommended for severe diabetic foot ulcers, radiation tissue damage, and deep infections that fail standard treatments.

Ischemic-Specific Interventions: Ischemic ulcers require urgent vascular assessment and revascularization procedures to restore blood flow. Adjunctive therapies like hyperbaric oxygen therapy or specialized matrix dressings are considered if standard care fails after 4–6 weeks without critical ischemia.

Multidisciplinary Approach: Managing high-grade or infected ulcers through coordinated care involving podiatrists, vascular surgeons, and infectious disease specialists drastically reduces amputation risks [3,5,7,9].

A study of a total of 211 patients diagnosed with DFU who were hospitalized and discharged from the hospital from October 2015 to January 2020 were divided into 2 groups according to whether the foot ulcer recurred during the 2-year follow-up period. First a recurrence group (n = 84) and second a non-recurrence group (n = 127). The results indicated that the 1) overall

recurrence rate of diabetic foot ulcers (DFU) within 2 years was a high 39.8%. (2) Significant differences were observed between the two patient groups in terms of BMI, HbA1c, TBIL, CRP, financial situation, foot deformity, first ulcer on the sole of the foot, previous amputation history, Wagner grade of the first ulcer, osteomyelitis, DFU duration (>60 days), lower limb vascular reconstruction, peripheral arterial disease (PAD), and diabetic peripheral neuropathy (DPN) (t = 2.455; Z = -1.988, -3.731, -3.618; χ^2 = 7.88, 5.004, 3.906, 17.178, 16.237, 5.007, 24.642, 4.782, 29.334, 10.253). No significant differences were found for the other indicators. [3]

Logistic regression analysis revealed that TBIL (Total Bilirubin, in blood test measurement of liver function) (OR = 0.886, p = 0.036) was a protective factor against ulcer recurrence. In contrast, PAD, previous amputation history, DPN, and the first ulcer on the sole of the foot (OR = 3.987, 6.758, 4.681, 2.405; p < 0.05 or p < 0.01) were identified as risk factors for ulcer recurrence. The study inferred that early screening and preventive education targeting high-risk factors such as DPN, PAD and the initial ulcer location on the sole of the foot are essential to mitigate the high long-term recurrence rate of DFU. Furthermore, the protective role of TBIL in preventing ulcer recurrence underscores the importance of monitoring bilirubin levels as part of a comprehensive management strategy for DFU patients [3].

Another meta-analysis identified male sex, smoking history, living alone, plantar ulcer, diabetic retinopathy, diabetic nephropathy, diabetic peripheral neuropathy, foot deformity, & peripheral arterial disease as important risk factors for diabetic foot ulcer recurrence [4].

More recent systematic review synthesised evidence from 66 studies that used classical statistical & machine learning approaches to identify factors associated with development of diabetic foot ulcers in people with diabetes. While 95 predictive factors were identified, with neuropathy, diabetes duration, age, body mass index, peripheral vascular disease, history of ulceration, foot deformities, hypertension, HbA1c levels, and fungal infections among the most frequently reported predictors [8].

A comparative study in a private hospital, Khammam, Telangana, it was inferred that in diabetics 6th decade and in non-diabetic's 4th-6th decade was the most common age group presenting with foot infections. Cellulitis of the foot was the most common in both diabetics (40%) and non-diabetics (52%). Wagner's grade 4 lesions were more common in diabetics (28%) than in non-diabetics (8%). The most common site of lesion in diabetics was dorsum (40%) and in non-diabetics was toes (40%). The incidence of neuropathy was significantly higher in diabetics (72%) than in non-diabetics (20%). Rate of amputation was high in diabetics (12%) compared to non-diabetics (8%). The average number days in a hospital stay in diabetics was 42.27 days and in non-diabetics it was 28.96 days [3].

Summary:

Foot ulcers in India are most caused by diabetic neuropathy, peripheral arterial disease, and venous insufficiency, with diabetic foot ulcers (DFUs) affecting up to 15% of individuals with diabetes in the country. Diabetic foot ulcers (DFUs) in India recur more frequently, present with deeper tissue damage, and carry a significantly higher risk of lower-limb amputation compared to non-diabetic recurrent foot ulcers.

Key Clinical Differences between diabetic and Non-diabetic Foot ulcers are: a) Peripheral neuropathy is drastically higher in diabetic patients b) Diabetic recurrent ulcers more frequently present as advanced lesions such as Wagner's grade 4 compared to milder or more superficial grades common in non-diabetic cohorts, Recurrent ulcers in diabetics frequently form on the dorsum (top) or plantar pressure points of the foot due to deformities, whereas non-diabetic recurrent ulcers often localize to the toes due to localized trauma or footwear friction, The rate of major and minor

amputations is notably higher in recurrent diabetic foot ulcers, and a prior amputation sharply multiplies the risk of subsequent contralateral or ipsilateral amputations over time

Understanding these factors and their impact on ulcer recurrence is crucial for multidisciplinary teams to develop management and treatment plans for diabetic foot ulcer patients.

Logistic regression and Cox regression were the most used and clinically interpretable predictive approaches. However modern machine learning methods help capture complex and nonlinear risk patterns to support early screening of high-risk patients of foot ulcers and reduce severe complications such as amputation.

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