

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Marisol T. Vandergriff

DOB

07/06/1979

AGE / SEX

47 yrs / Female

MRN / PATIENT ID

8842106

DATE OF SERVICE

08/05/2026

PROVIDER

Aaron Delacroix, DPM

CREDENTIALS

DPM

REFERRAL SOURCE

Transplant nephrology — new foot swelling and non-healing ulcer

VISIT TYPE

Ulcer Follow-Up with urgent same-day assessment of the contralateral foot

CARE SETTING

Outpatient Podiatry Clinic

PRIMARY CARE PROVIDER

Corinne Bexley, MD

ENDOCRINOLOGIST

Ravi Sundaresan, MD

PODIATRIST / WOUND CARE PROVIDER

This service — established since 05/2026

CC CHIEF COMPLAINT

2 PRIMARY DIABETIC FOOT CONCERN

"The sore under my right big toe joint still isn't closed after three months. But what worries me more is my left foot — it's been hot and swollen for about two weeks and there's no cut on it at all. My transplant nurse told me to come in today rather than wait."

S SUBJECTIVE

3 PATIENT-REPORTED FOOT SYMPTOMS, WOUND HISTORY, PREVENTIVE CARE & ADHERENCE

3a INDICATION, DIABETES & FOOT SYMPTOMS

Reason for Diabetic Foot Care Evaluation

Scheduled follow-up of a right plantar neuropathic ulcer at week 12, converted to an urgent dual assessment after two weeks of unexplained left foot swelling, warmth, and erythema without any breach of skin. Visit purpose: remeasurement and offloading review of the right ulcer, urgent evaluation of the left foot for acute Charcot neuroarthropathy, exclusion of infection in both feet, and revision of the offloading strategy now that both limbs are affected.

Diabetes History

Type 1 diabetes diagnosed at age 16, duration 31 years. Insulin pump with continuous glucose monitoring since 2019. Most recent HbA1c 7.4% on 07/20/2026, with a time-in-range of 68% and improving since transplant. Hypoglycemia unawareness was a major problem before her transplant and has substantially improved; two level-2 hypoglycemic events in the last 90 days, both nocturnal. Established complications: dense sensorimotor peripheral neuropathy, autonomic neuropathy with gastroparesis, proliferative retinopathy treated with laser and stable, and diabetic nephropathy that progressed to ESRD requiring a deceased-donor kidney transplant in 11/2024. She is now 21 months post-transplant with a stable creatinine of 1.15 on tacrolimus, mycophenolate, and prednisone 5 mg daily.

Foot Symptoms

Right foot: she cannot feel the ulcer at all and has never had pain from it; she monitors it only visually with a mirror. No drainage change reported. **Left foot:** two weeks of progressive swelling, warmth she describes as “like it has a fever of its own,” and redness of the whole midfoot. She denies any cut, blister, puncture, or injury. She recalls no specific trauma, though she notes she walked considerably more than usual at a family wedding three weeks ago. The left foot feels “heavy and loose” when she walks. No pain in either foot, which she volunteers is what most reassured her and is precisely why she delayed presenting.

Wound / Ulcer History

Right plantar ulcer beneath the first metatarsal head, first noticed 05/04/2026 as a blood blister under a long-standing callus, discovered on routine visual inspection rather than felt. No recalled inciting trauma. Debrided at first presentation on 05/11 to reveal a 1.4 cm full-thickness ulcer. It has been managed with weekly debridement and a removable cast walker. Trajectory: 1.4 cm at week 0, 0.9 cm at week 6, 0.8 cm at week 9, and 0.8 cm today — **a plateau over the last six weeks**. Scant serous drainage throughout, never purulent, never malodorous. No prior ulcer at this or any other site.

3b NEUROPATHY, VASCULAR & INFECTION SYMPTOMS

Neuropathy Symptoms

Dense loss of protective sensation to the mid-calf bilaterally, present for at least eight years. Nocturnal burning dysesthesia in both feet, controlled on duloxetine. Complete inability to detect the plantar ulcer or the left foot changes by sensation. Two episodes of unnoticed minor trauma in the past year — a splinter and a thermal burn from a hot bath. Balance is impaired with two near-falls in six months; she uses a handrail on stairs. Gait feels “unsteady on the left” since the swelling began.

Vascular Symptoms

No claudication, no rest pain, no cold feet, and no colour change. Wounds elsewhere on her body heal normally. No prior vascular testing, no revascularization, and no known peripheral arterial disease. Both feet are subjectively warm to her, and the left is warmer than the right. This is important — her clinical picture is neuropathic rather than ischemic, which fundamentally changes the management from the ischemic diabetic foot.

Infection Symptoms

No fever, chills, rigors, malaise, or systemic symptoms. No increase in right ulcer pain (she cannot feel it), no purulent drainage, no foul odour, no streaking, and no wound expansion. The left foot erythema is diffuse over the midfoot rather than tracking from any portal of entry, and there is no break in the skin anywhere on that foot. No prior foot infection, cellulitis, or osteomyelitis. She notes the left redness fades substantially when she keeps her foot up for half an hour, which she demonstrated at home.

3c FOOTWEAR, SELF-CARE HISTORY & BARRIERS

Footwear / Offloading History

Custom diabetic shoes with total-contact inserts issued 01/2026, well fitted and in good condition. Removable cast walker issued 05/11/2026 for the right ulcer. **Adherence to the walker is the central problem** — she reports wearing it “most of

the time out of the house” but removes it at home, at work when seated then forgets to replace it, and she did not wear it at all for the wedding three weeks ago. She estimates genuine adherence at 50–60%. She has never had a total contact cast. No brace, prosthetic, or heel protector. She does not walk barefoot and is reliable on that point.

Skin and Nail Care History

Dry skin managed with daily urea-based emollient, applied to the dorsum and plantar surface but not between the toes, as instructed. Long-standing plantar callus at both first metatarsal heads. No corns. Mild onychomycosis of both halluces and the right fifth toenail, unchanged. She does not self-trim her nails and has not since her transplant. Podiatric care every 8 weeks until the ulcer, then weekly. She inspects both feet daily with a long-handled mirror — a habit she has kept reliably, and the reason both problems were found early.

Prior Foot History

No prior diabetic foot ulcer before 05/2026. No prior foot infection, osteomyelitis, Charcot arthropathy, amputation, foot surgery, or revascularization. No foot-related hospitalization. Podiatric care has otherwise been preventive only.

Functional Impact

Works full-time from home as an insurance claims adjuster, largely seated — a favourable factor for offloading. Walks her dog twice daily, approximately 1.5 km in total, which she is reluctant to give up. Stands for cooking and household tasks. Sleep is undisturbed. Drives an automatic vehicle with the right foot, which is directly relevant to the offloading decision. No mobility aid. She is independent in all activities of daily living. Quality of life is currently good and she is highly motivated to keep it that way.

Risk Factors for Foot Complications

Dense peripheral neuropathy with complete loss of protective sensation, a current active ulcer, bilateral plantar callus and forefoot deformity, 31 years of type 1 diabetes, prednisone 5 mg daily plus tacrolimus and mycophenolate (immunosuppression impairing both healing and the inflammatory signs of infection), a functioning renal transplant with a creatinine of 1.15, and partial offloading adherence. Protective factors are equally real and worth documenting: intact pulses, no PAD, never smoked, normal nutrition with an albumin of 4.0, excellent daily self-inspection, good vision, full cognition, and a supportive partner.

Medication and Treatment Adherence

Insulin pump therapy with CGM, tacrolimus 3 mg twice daily, mycophenolate 720 mg twice daily, prednisone 5 mg daily, duloxetine 60 mg daily, atorvastatin 20 mg nightly, amlodipine 5 mg daily, and a urea 25% emollient. Adherence to all medications is excellent and verified against pharmacy records. Dressing changes are performed reliably by the patient.

The single adherence gap is offloading, and she is candid about it.

Pertinent Negatives

No fever or systemic illness. No rapidly spreading redness, purulence, foul odour, fluctuance, crepitus, or bullae. No black discoloration or gangrene in either foot. No rest pain, no cold foot, no colour change. No new numbness or weakness beyond her chronic neuropathy. No portal of entry anywhere on the left foot on careful inspection by both the patient and this examiner.

ROS DIABETIC FOOT CARE REVIEW OF SYSTEMS	
4 PERTINENT POSITIVES & NEGATIVES	
Foot pain, numbness, tingling, burning, or loss of sensation	Positive — dense bilateral loss of protective sensation, nocturnal burning on duloxetine. No pain in either foot despite significant pathology.
Foot ulcer, wound drainage, odor, bleeding, redness, warmth, or swelling	Positive — right plantar ulcer with scant serous drainage, plateaued at 0.8 cm. Left midfoot swelling, warmth, and erythema with intact skin.
Callus, corn, cracked skin, nail thickening, ingrown nail, or	Positive — bilateral first metatarsal head callus, mild

Corns, callus, cracked skin, nail thickening, ingrown nail, or fungal nail changes	Positive — bilateral first metatarsal head callus, mild onychomycosis of both halluces and the right fifth toenail.
Claudication, rest pain, cold foot, color change, or delayed wound healing	Negative for all vascular symptoms — this is a neuropathic, not an ischemic, presentation.
Fever, chills, fatigue, or systemic infection symptoms	Negative — afebrile, no systemic features.
Balance problems, falls, gait difficulty, or difficulty wearing shoes	Positive — impaired balance, two near-falls in 6 months, new sense of instability on the left.
Hyperglycemia, hypoglycemia, poor appetite, weight change, or medication adherence	Two nocturnal level-2 hypoglycemic events in 90 days. HbA1c 7.4%, time-in-range 68%. Medication adherence excellent.
Dressing, offloading, footwear, or home foot care barriers	Positive — offloading adherence approximately 50–60%, the dominant barrier. Dressing changes and daily inspection are reliable.

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OBJECTIVE

5

OBSERVED FINDINGS

V

VITALS

TEMPERATURE

36.9 °C

HEART RATE

78 bpm

OXYGEN SATURATION

99% on room air

BMI

25.1 kg/m²

BLOOD PRESSURE

122/74 mmHg

RESPIRATORY RATE

14 /min

WEIGHT

68.4 kg

PAIN SCORE

0/10 in both feet — absence of pain is itself a red flag here

5a

GENERAL & VASCULAR EXAMINATION

General Appearance

Well-appearing, well-groomed, no distress. Independently mobile with a mildly antalgic and slightly wide-based gait, favouring the left midfoot. Nutritionally well. Fully engaged, asks informed questions, and is entirely capable of participating in her own foot care.

Vascular Examination

Both feet: dorsalis pedis and posterior tibial pulses palpable at 2+ and symmetric. Triphasic Doppler waveforms at all four pedal sites. Capillary refill under 2 seconds in all toes. Both feet warm; **the left is measurably warmer** — infrared skin temperature 34.8 °C at the left midfoot versus 30.6 °C at the matched right site, a difference of 4.2 °C. No dependent rubor and no pallor on elevation in either foot. Hair growth preserved on both dorsa. No varicosities or stasis change. **Left midfoot erythema resolves almost completely after 8 minutes of elevation and returns within 3 minutes of dependency** — a positive elevation test. There is no evidence of peripheral arterial disease in either limb.

5b

NEUROLOGIC, STRUCTURAL, SKIN & NAIL EXAMINATION

Neurologic Examination

Loss of protective sensation confirmed bilaterally — 10 g Semmes-Weinstein monofilament absent at 10 of 10 sites on the right and 9 of 10 on the left. Vibration absent at both halluces on 128 Hz tuning fork; biothesiometer threshold above 45 V bilaterally. Proprioception impaired at the toes bilaterally. Ankle reflexes absent, knee reflexes reduced. Motor strength 5/5 throughout with no foot drop or intrinsic wasting beyond mild clawing. Gait wide-based with reduced heel strike on the left. She cannot detect injury or pressure anywhere on either forefoot or midfoot.

Musculoskeletal / Foot Structure

Right foot: prominent first metatarsal head with a plantarflexed first ray, mild hallux limitus with 30 degrees of dorsiflexion, and clawing of the second through fourth toes. Longitudinal arch preserved. **Left foot:** the midfoot is grossly swollen and warm with a **flattened medial longitudinal arch and early plantar prominence at the medial cuneiform-navicular region**. Passive midfoot range of motion is increased and there is a palpable instability on medial column stress testing, without frank rocker-bottom deformity. No fixed collapse yet. Ankle range of motion preserved bilaterally. No amputation. Both custom shoes inspected — well fitted, inserts intact, no foreign body.

Skin Examination

Right: plantar ulcer beneath the first metatarsal head as detailed below, ringed by a thick hyperkeratotic rim. Dry skin over both heels with early fissuring, no full-thickness cracks. **Left: skin is completely intact** — no ulcer, blister, fissure, puncture, abrasion, or interdigital breach anywhere on careful inspection including the web spaces and beneath the nails. Diffuse erythema over the dorsal and medial midfoot, blanching and elevation-dependent. Marked pitting edema of the midfoot and ankle. No cellulitic tracking, no lymphangitis, no fluctuance, no crepitus, no bullae, no necrosis. Mild interdigital tinea bilaterally in the fourth web spaces.

Nail Examination

Mild onychomycosis of both hallux nails and the right fifth toenail with thickening and yellow discoloration, non-tender, without subungual haematoma or debris. Nails professionally trimmed and of appropriate length. No ingrown nail, no paronychia, no traumatic nail change.

RA DIABETIC FOOT RISK ASSESSMENT

6 RISK LEVEL DETERMINATION

PERIPHERAL NEUROPATHY

Present and severe — monofilament absent 10/10 right and 9/10 left; vibration absent bilaterally

PERIPHERAL ARTERIAL DISEASE

Absent — 2+ pedal pulses, triphasic waveforms bilaterally

PRIOR FOOT ULCER HISTORY

Current active ulcer since 05/2026; no ulcer before that

PRIOR AMPUTATION HISTORY

None

CURRENT ULCER OR WOUND STATUS

Right plantar first MTH ulcer, 0.8 cm, plateaued for 6 weeks; left foot skin intact

FOOT DEFORMITY OR CHARCOT CHANGES

Yes — suspected acute Charcot neuroarthropathy of the left midfoot; plantarflexed first ray and digital clawing on the right

CALLUS OR PRESSURE AREAS

Bilateral first metatarsal head callus with a hyperkeratotic rim around the right ulcer

FOOTWEAR ADEQUACY

Custom diabetic shoes appropriate and well fitted; removable cast walker in place but under-used

ABILITY TO PERFORM SELF-FOOT INSPECTION

Excellent — daily mirror inspection, good vision, full cognition; both problems were self-detected

OVERALL RISK CATEGORY

IWGDF risk category 3 (very high) — neuropathy with an active ulcer; screening interval 1–4 weeks

Vision, mobility, cognitive, or caregiver limitations affecting foot care

No limitation. Vision is 20/25 bilaterally with stable treated retinopathy. Cognition intact. Independently mobile. Partner available and willing to assist with inspection and dressing if needed. Sedentary home-based employment is an asset for offloading. The only behavioural barrier is her attachment to twice-daily dog walking and her habit of removing the walker indoors — both specific, addressable, and not a matter of comprehension.

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WOUND / ULCER ASSESSMENT

7 RIGHT PLANTAR FIRST METATARSAL HEAD ULCER

WOUND NUMBER

1 of 1 — left foot has no wound

LOCATION AND LATERALITY

Right plantar forefoot, directly beneath the first metatarsal head

WOUND TYPE OR SUSPECTED ETIOLOGY

Neuropathic plantar ulcer — repetitive pressure beneath a plantarflexed first ray under callus

DATE FIRST ASSESSED

05/04/2026 by the patient; 05/11/2026 by this service

DIMENSIONS

0.8 cm × 0.7 cm × 0.3 cm before debridement (0.8 × 0.7 × 0.3 cm on 07/22 — unchanged)

WOUND CLASSIFICATION OR GRADE

University of Texas Grade 1, Stage A — superficial, no infection, no ischemia

EXUDATE AMOUNT, COLOR, CONSISTENCY, ODOR

Scant, serous, clear, no odour

WOUND PHOTOGRAPHS OBTAINED

Yes — 2 images with scale, filed to the chart

Undermining and tunneling

None. No undermining at any clock position and no sinus tract. **Probe-to-bone negative** — the probe meets soft, healthy subcutaneous tissue at 0.3 cm with no gritty or bony endpoint.

Wound bed tissue type

Approximately 90% healthy red granulation and 10% fine fibrinous film. No slough, eschar, or necrosis. No exposed tendon, bone, joint, capsule, or hardware. The wound bed itself is entirely healthy — this ulcer is failing on mechanics, not on biology.

Wound edges and periwound condition

Edges are thickly hyperkeratotic and rolled, forming a raised callus rim 3–4 mm wide that mechanically prevents epithelial advance — the classic appearance of an under-offloaded plantar neuropathic ulcer. Periwound skin is otherwise healthy, dry, non-macerated, and non-erythematous. No induration, warmth, or fluctuance.

Bleeding, friability, signs of infection or ischemia

Brisk, bright bleeding on debridement indicating excellent perfusion. Granulation is firm, not friable. **No signs of infection whatsoever** — no erythema, warmth, induration, purulence, odour, or systemic features, and no probe-to-bone. No ischemia. No abscess or deep tissue involvement.

Pain and comparison to prior measurements

No pain on probing or debridement, consistent with dense neuropathy. **Six-week plateau at 0.8 cm following an initial 43% reduction in the first six weeks.** A wound that fails to reduce by at least 50% at four weeks, or that plateaus after an initial response in a well-perfused, non-infected foot, has an offloading problem until proven otherwise.

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DIABETIC FOOT CLASSIFICATION

8 CLASSIFICATION — BOTH FEET

WAGNER GRADE

Right: Grade 1 — superficial ulcer. Left: not applicable, skin intact

WIFI CLASSIFICATION

Right: W1 I0 fI0 — clinical stage 1, very low amputation risk. Left: not applicable

CHARCOT STAGE OR DEFORMITY STATUS

Left: suspected Eichenholtz Stage 1 (fragmentation / acute inflammatory), Sanders-Frykberg pattern II–III (Lisfranc / naviculocuneiform) — warm, swollen, erythematous, unstable midfoot with intact skin. Right: plantarflexed first ray with digital clawing, no Charcot

OSTEOMYELITIS CONCERN

Low for the right ulcer — superficial at 0.3 cm, probe-to-bone negative, no infection signs. Nil for the left, which has no portal of entry

Exposed tendon, bone, joint, capsule, or hardware

None in either foot. The right ulcer is superficial to subcutaneous tissue only.

Overall amputation risk

Low in the short term, but the medium-term risk is being set today. The right ulcer is superficial, well perfused, and uninfected. The material threat is the left foot: untreated acute Charcot progresses to rocker-bottom collapse, which produces a new plantar prominence, a new ulcer, and a genuine amputation risk. Immobilisation now is what prevents that trajectory.

UNIVERSITY OF TEXAS CLASSIFICATION

Right: Grade 1, Stage A — superficial, no infection, no ischemia

PRESSURE INJURY STAGE

Not applicable to either foot

GANGRENE EXTENT AND LOCATION

None in either foot

ABSCESS OR DEEP SPACE INFECTION CONCERN

None in either foot — no fluctuance, purulence, crepitus, or systemic features

PR PROCEDURES PERFORMED

9 PROCEDURES THIS VISIT

PROCEDURE NAME

(1) Sharp debridement of the right plantar ulcer with callus rim excision; (2) total contact cast application, left lower limb; (3) comprehensive diabetic foot examination, bilateral

FOOT / WOUND LOCATION AND LATERALITY

Right plantar first metatarsal head; left lower limb below the knee

ANESTHESIA, IF USED

None — dense loss of protective sensation; patient confirmed no sensation throughout

TISSUE, NAIL, OR CALLUS REMOVED

Hyperkeratotic rim and thin fibrinous film from the right ulcer, approximately 1.1 cm²; no nail procedure performed

INDICATION

Hyperkeratotic rim preventing epithelial advance; acute Charcot requiring immediate immobilisation; risk-category 3 surveillance exam

CONSENT

Verbal consent obtained and documented for both procedures, including casting risks explained

INSTRUMENTS USED

#15 blade, tissue nipper, curette; cast saw, stockinette, felt padding, plaster and fibreglass

BLEEDING / HEMOSTASIS

Brisk punctate bleeding at the debrided rim; hemostasis with 90 seconds of direct pressure

POST-PROCEDURE MEASUREMENTS

Right ulcer 0.9 cm × 0.8 cm × 0.3 cm after rim excision — larger by design following removal of the callus shoulder

DRESSING AND OFFLOADING APPLIED

Right: non-adherent contact layer with foam, felt aperture pad, and removable cast walker refitted. Left: total contact cast applied

Technique

Right ulcer: the hyperkeratotic rim was excised sharply back to a healthy, thin, bleeding epithelial edge with a #15 blade, and the fibrinous film curetted from the base. The apparent increase in measured area is the expected and intended consequence of removing the callus shoulder and should not be read as deterioration. Cleansed with saline and dressed with a non-adherent contact layer, foam, and a felt aperture pad to redistribute pressure away from the first metatarsal head. No culture taken — there is no clinical infection and swabbing an uninfected ulcer yields only colonising flora. **Left limb:** a well-moulded total contact cast was applied below the knee over stockinette with felt protection of the malleoli, tibial crest, and toes, with the foot held at 90 degrees in neutral alignment and generous forefoot padding. The right removable cast walker was refitted and its rocker sole checked. Interdigital tinea treated topically bilaterally.

Patient tolerance and complications

Both procedures tolerated without difficulty and without pain, as expected. No bleeding complication. No vasovagal event. Full instruction given in cast care and in the specific warning signs requiring immediate removal. Ambulated in the cast with a walking heel before discharge without difficulty. No complications.

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LABORATORY AND DIAGNOSTIC RESULTS

10 RESULTS REVIEWED OR ORDERED

Diabetes / Metabolic Labs — 07/20/2026

HbA1c 7.4% with a CGM time-in-range of 68% and a glucose management indicator of 7.2%. Fasting glucose 132 mg/dL. Creatinine 1.15 mg/dL with an eGFR of 58 — stable transplant function. CMP otherwise normal. Albumin 4.0 g/dL and prealbumin 27 mg/dL — nutrition is not a healing barrier here. LDL-C 74 mg/dL on atorvastatin. Tacrolimus trough 6.4 ng/mL, within target.

Infection Labs

White cells 7.1 K/ μ L with a normal differential. ESR 24 mm/hr and CRP 9 mg/L — mildly elevated and entirely consistent with acute Charcot inflammation rather than infection; note that immunosuppression may blunt these markers, so they cannot be used to exclude infection on their own and the clinical picture carries more weight. No culture taken from either foot — no clinical infection at either site. No history of resistant organism colonisation.

Imaging

Left foot radiograph, three views, obtained today: subtle subluxation at the second and third tarsometatarsal joints with a loss of the normal Lisfranc alignment, early periarticular fragmentation at the naviculocuneiform joint, and soft tissue swelling. No cortical destruction, no periosteal reaction, no soft tissue gas. Findings support early Charcot neuroarthropathy. **Left foot MRI without contrast ordered urgently** to confirm the diagnosis, stage the disease, and definitively exclude osteomyelitis; non-contrast chosen given the renal transplant. Right foot radiograph 05/11/2026 showed a plantarflexed first ray with no osseous abnormality and has not been repeated as the ulcer remains superficial with a negative probe-to-bone.

Vascular Studies

Bedside assessment today: palpable 2+ pedal pulses bilaterally with triphasic Doppler waveforms at all four sites. **Formal ABI, TBI, and toe pressures are not indicated** — the clinical vascular examination is unequivocally normal, and a falsely elevated ABI from medial calcinosis would add nothing. Documented explicitly so that the absence of vascular testing is not later read as an omission. No prior or planned angiography.

Pathology

No bone biopsy or tissue pathology performed or indicated. The right ulcer is superficial and uninfected; the left foot has no portal of entry and no clinical infection.

Prior Records Reviewed

All podiatry clinic notes and serial wound measurements from 05/11/2026 to 07/22/2026 with the full photographic series, transplant nephrology notes and immunosuppression record, endocrinology notes with CGM download and pump settings, the 01/2026 custom footwear prescription and fitting record, and the 05/11 right foot radiograph. Approximately 17 minutes of independent record review.

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ASSESSMENT

11 DIABETIC FOOT CARE CLINICAL INTERPRETATION

- **Acute Charcot neuroarthropathy of the left midfoot, Eichenholtz Stage 1, is the urgent finding of this visit and takes precedence over the ulcer.** A hot, swollen, erythematous, unstable midfoot with a 4.2 °C temperature differential, a positive elevation test, intact skin with no portal of entry, and radiographic tarsometatarsal subluxation in a densely neuropathic foot is Charcot until proven otherwise.
- **The principal differential is cellulitis, and it is confidently excluded on clinical grounds:** there is no break in the skin anywhere on the left foot, the erythema is diffuse rather than tracking from a portal, it resolves on elevation and returns on dependency, she is afebrile with a normal white cell count, and there is no lymphangitis or regional adenopathy. Deep vein thrombosis and acute gout were also considered and are not supported by the distribution or the radiographic findings.
- **Charcot is very frequently missed at exactly this stage** — it is painless in a neuropathic foot, it is commonly mistaken for infection and treated with antibiotics while the patient keeps walking, and the resulting rocker-bottom collapse is what ultimately produces a plantar ulcer over the new bony prominence and a real amputation risk. Immobilisation today is what changes that trajectory. This is a time-critical diagnosis with a non-time-critical presentation.
- **Right plantar neuropathic ulcer, University of Texas Grade 1 Stage A, plateaued at six weeks — the cause is mechanical, not biological.** The wound bed is 90% healthy granulation with brisk bleeding, perfusion is excellent, there is no infection, nutrition is normal, and glycemic control is reasonable. Every element of healing biology is favourable. What is failing is offloading, at an estimated 50–60% adherence, together with a hyperkeratotic rim that mechanically obstructs epithelial advance.
- **Removable devices fail because they are removable.** Her honest account — walker off indoors, off at the desk, off entirely for a wedding — is the single sufficient explanation for a six-week plateau in an otherwise ideal healing environment. This is not non-compliance to be reproached; it is a predictable property of removable offloading that calls for a change of device.
- **No infection at either site.** Right ulcer: superficial at 0.3 cm, probe-to-bone negative, no erythema, warmth, purulence, or odour. Left foot: no portal of entry. No antibiotic is indicated at either site, and prescribing one would delay the correct diagnosis on the left.
- **No peripheral arterial disease.** Palpable 2+ pulses with triphasic waveforms bilaterally. This is a purely neuropathic foot, which fundamentally changes management from the ischemic diabetic foot: total contact casting is appropriate and safe here, whereas it would be contraindicated with significant ischemia.
- **Immunosuppression is a genuine but manageable modifier.** Prednisone, tacrolimus, and mycophenolate impair healing and blunt the inflammatory response, so normal inflammatory markers cannot be relied upon to exclude infection and any future infection may present atypically and late. A lower threshold for imaging and review is warranted throughout.
- **IWGDF risk category 3 (very high) bilaterally** — neuropathy with an active ulcer. She requires surveillance every 1–4 weeks indefinitely, and lifelong protective footwear.

- **Her self-care is a major clinical asset and should be named as such.** Daily mirror inspection detected both problems, she never walks barefoot, medication adherence is complete, nutrition is normal, and she has never smoked. The prognosis is genuinely good if both feet are immobilised now.
- **Formulation:** immobilise the left foot in a total contact cast today; convert the right to a non-removable or functionally non-removable device; expect the ulcer to close within 4–6 weeks once offloading is genuinely enforced; expect the Charcot to require 3–6 months of casting with serial temperature and radiographic monitoring.

P

PLAN

12 DIABETIC FOOT CARE MANAGEMENT BY PROBLEM

- **Left foot — acute Charcot, immediate immobilisation (done today):** total contact cast applied below the knee. Strict non-weight-bearing to partial weight-bearing with crutches or a knee scooter, and she was told explicitly that walking on an acute Charcot foot is what causes the collapse. Cast changes weekly for the first 3 weeks while the swelling reduces, then every 2 weeks. Serial infrared skin temperature at every visit, with the endpoint for cast discontinuation defined as a temperature differential under 2 °C sustained across two consecutive visits together with radiographic consolidation — anticipated at 3–6 months. Serial radiographs every 4–6 weeks. Urgent non-contrast MRI to confirm the diagnosis, stage the disease, and exclude osteomyelitis. Bisphosphonate therapy considered and **not** started — the evidence for benefit is weak and she has a renal transplant; immobilisation is the treatment.
- **Right ulcer — convert to genuine offloading:** the removable cast walker is to be rendered non-removable at the next visit by wrapping it with cohesive bandage (an instant total contact cast), or replaced by a second total contact cast if she prefers. The clinical logic was explained to her directly and without reproach — this is a change of device, not a reprimand. Weekly sharp debridement of the hyperkeratotic rim at every visit; this alone is frequently the difference between a plateau and closure. Non-adherent contact layer with foam and a felt aperture pad, changed every 2–3 days by the patient.
- **Bilateral casting and mobility — addressed proactively:** with the left in a cast and the right in a non-removable device, mobility and falls become a real risk in a patient with impaired balance and two prior near-falls. Urgent physiotherapy referral placed for gait training, a knee scooter, and falls prevention. Occupational therapy for home adaptation. She was told plainly that she must not drive while the right foot is in a non-removable device, and alternative transport was arranged with her partner. **Dog walking must stop entirely for now** — discussed directly since she had identified it as her main reluctance, and a dog-walking service was suggested.
- **Infection:** no antibiotic indicated at either site, and the reasoning was documented explicitly so that another clinician does not reflexively treat the left foot erythema as cellulitis. Escalation criteria given in writing: fever, purulent drainage, foul odour, spreading redness that does not resolve on elevation, or any new skin breach warrants same-day contact. A lower threshold for review applies given immunosuppression.
- **Vascular:** no further testing indicated — pulses palpable with triphasic waveforms bilaterally. Documented so that the absence of testing is not later misread. Reassess clinically at every visit.
- **Diabetes optimization:** HbA1c 7.4% with a time-in-range of 68% is reasonable and no urgent change is required. Endocrinology asked to review the overnight basal rate given two nocturnal level-2 hypoglycemic events. Prednisone-related glycemic variability discussed with transplant nephrology; no change to immunosuppression at this stage.
- **Neuropathy management:** continue duloxetine 60 mg daily, which is providing adequate control of the burning dysesthesia. Reinforced that the absence of pain is a hazard and not reassurance — she must rely on daily visual inspection, not sensation, and this principle now extends to inspecting the skin at the cast edges.
- **Preventive foot care, both feet:** continue daily mirror inspection, now extended to the cast margins and the exposed toes. Urea 25% emollient daily to the dorsum and plantar surface but never between the toes. No barefoot walking under any circumstance, including at home. Nail and callus care by this service only, every 4

weeks while the ulcer is active. Topical antifungal to both fourth web spaces twice daily for 14 days for interdigital tinea — a common and under-treated portal of entry.

- **Footwear planning:** her current custom shoes will not accommodate a Charcot foot after consolidation. Orthotics referral placed now for future custom moulded shoes with a rigid rocker sole and, depending on the final deformity, a Charcot restraint orthotic walker or an ankle-foot orthosis. Planning early avoids a gap between cast removal and protective footwear — the period in which re-ulceration most often occurs.
- **Nutrition and healing:** albumin 4.0 and prealbumin 27 — nutrition is adequate and no intervention is needed. Documented so that supplementation is not added reflexively.
- **Coordination:** note routed to Dr. Bexley (primary care), Dr. Sundaresan (endocrinology), and transplant nephrology. Referrals placed to physiotherapy, occupational therapy, and orthotics. Transplant nephrology specifically notified that she is in bilateral offloading devices and that any future foot infection may present atypically on immunosuppression.
- **Patient education:** 24 minutes spent explaining what Charcot is and why a painless hot foot is an emergency, why the ulcer plateaued and why the device must change, the driving and dog-walking restrictions and the reasons behind them, cast care and the warning signs requiring immediate removal, and the realistic 3–6 month timeline. Written instructions and a cast-care sheet provided. She was explicitly commended for the daily inspection that found both problems.

F

FOLLOW-UP

13 REASSESSMENT PLAN

Follow-up timeframe and purpose

Podiatry in 7 days (08/12/2026) for the first left cast change, right ulcer debridement and remeasurement, conversion of the right walker to a non-removable device, infrared temperature measurement of both feet, and MRI review. Then weekly for 3 weeks, then every 2 weeks while casting continues. Left foot radiograph every 4–6 weeks. Cast discontinuation gated on a temperature differential under 2 °C sustained over two consecutive visits plus radiographic consolidation.

Physiotherapy within 1 week. Orthotics within 4 weeks for future footwear planning. Endocrinology within 4 weeks for the nocturnal hypoglycemia review. Lifelong podiatric surveillance every 1–4 weeks as IWGDF risk category 3. **Same-day contact** instructed for fever, any new skin breach or drainage, cast discomfort or a wet or damaged cast, purulence, foul odour, spreading redness that does not resolve on elevation, or any fall.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

68 minutes

PROCEDURE TIME

30 minutes — debridement 9 minutes, total contact cast application 21 minutes

COUNSELING / COORDINATION OF CARE TIME

24 minutes — Charcot education, offloading renegotiation, activity restrictions

RECORDS REVIEW TIME

17 minutes

HOME HEALTH / SUPPLY COORDINATION TIME

7 minutes — knee scooter, physiotherapy, orthotics referral

BASIS FOR BILLING

Procedure-based plus Medical Decision Making (high complexity), separately identifiable E/M

E/M LEVEL

99215 with modifier 25 — established patient, high MDM (new acute Charcot diagnosis)

DIABETIC FOOT EXAM CODE(S)

G0245 — initial physician evaluation of a diabetic patient with loss of protective sensation (bilateral comprehensive exam documented)

NAIL / CALLUS PROCEDURE CODE(S)

Not billed — callus rim excision is integral to the ulcer debridement

DEBRIDEMENT CODE(S)

11042 — debridement, subcutaneous tissue, first 20 sq cm or less

WOUND PROCEDURE CODE(S)

Not applicable — no culture, biopsy, or graft

OFFLOADING / CAST / ORTHOTIC CODE(S)

29445 — application of rigid total contact leg cast, left; A9283 — foot pressure offloading device, right

PRIMARY ICD-10 DIAGNOSIS CODE

E10.610 — Type 1 diabetes mellitus with diabetic neuropathic arthropathy (Charcot, left foot)

SECONDARY ICD-10 DIAGNOSIS CODE(S)

E10.621 — Type 1 diabetes with foot ulcer; L97.511 — Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin; E10.42 — Type 1 diabetes with diabetic polyneuropathy; M14.672 — Charcot's joint, left ankle and foot; Z94.0 — Kidney transplant status; Z79.51 — Long term use of systemic steroids; Z79.899 — Other long term drug therapy (immunosuppressants); E10.359 — Type 1 diabetes with proliferative retinopathy; B35.3 — Tinea pedis; B35.1 — Tinea unguium

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Aaron Delacroix, DPM

CREDENTIALS

DPM

SPECIALTY

Diabetic Foot Care / Podiatry

DATE

08/05/2026

TIME

12:15 PM