



# Division of Diabetes Treatment and Prevention

## Diabetes Foot Care

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Kendall Shumway:

Riverside-San Bernardino County Indian Health is located about 60 miles east of Los Angeles. It covers those two counties. San Bernardino is the largest county in United States in the lower 48 and Riverside, I think, is like 26th or 25th or something like that. It's a large area with seven clinics that are spread out over quite a big, big area.

I'm just going to skip over the statistics because I think you can get those in a lot of places but obviously, diabetes and risk of amputation in the Indian community is a large risk factor and it's something that we need to be worried about.

So how do the amputations happen? I think what we'd like to talk about is how do you prevent that from happening. I know this is very simplistic but oftentimes, there is some type of injury and there's an infection and infection spreads, and really then just stop that spread of infection or the non-healing parts of the foot and sometimes they do have to be amputated. So, I'll try to make this presentation more about primary care and screening within the clinics. So how do you approach the diabetic foot in the primary care setting? There are things to look for just in the patient's background, things that make amputations more likely. Diabetes over at certain period of time like 10 to 15 years, kidney problems and obviously, neuropathy are risk factors that lead to that.

Here's another list that I just had gathered overtime of different articles that were statistically significant for factors that can lead to amputation and alterations. And interesting if somebody's note their limited joint mobility, if they can't hold their foot up close enough to their eyes and they have some vision loss and they can't see, then those things are going to make it more likely. They might get an ulcer and not be able to take care of it very well. So I did include a couple of handouts that I thought were excellent, and again focus more in the primary care clinic. It's an article by David Armstrong and some of his group from University of Arizona in Tucson, Three-Minute Foot Exam.

Now, I do want to do a poll right here just to get an idea what is happening in some of your clinics, so if you take a minute and click on one of those. When we're talking about screening in primary care, this should be quick. There's a visual, look at the circulation, see if the nerves are working, looking at deformities, and again, evaluating risks. It is interesting because I think a lot of times as the patients come in, I'm seeing that number three is -- I'm glad to see that so many are doing foot exams routinely. But also, just as patients come in, they have 15 to 20 minutes with their patient and they have many urgent concerns and problems that we're managing that can really make it difficult to handle that. I hope we can look at how you might be able to overcome some of those challenges. We'll go ahead to the next slide. I appreciate your input there.

Peripheral neuropathy is one of the biggest risk factors. Really, what is it? There are several theories about what happens or what causes the nerves to be damaged from diabetes including microvascular damage with basement membrane thickening. Another is the glucose is changed into sorbitol, which then is not absorbable or stays and hangs out around the nerves causing damage over time, swelling



and edema that puts pinching on the nerves. But really what ends up happening -- see if I can get my pointer to work. It doesn't seem to be. It worked before we started.

Anyway, if you look at the one filament, the axon and what wraps around that are Schwann cells and they're protective to the nerve. That is what ends up being damaged. It damages the axon, so they can't send signals. There are different types of neuropathy that show up in the feet. One is the motor nerve damage. You can see in this foot how it's very thin, the digits are hammered a little bit. Sometimes, what happens is the small muscles in the foot aren't able to keep the feet and the toes stabilized. So that's one area where there can be weakness as well.

Another area is sensory nerve damage, where the patient can't feel. This is a patient who walked out to the street to get his newspaper and he wasn't wearing his shoes or sandals and walked out, and as he walked back in his house, he could see there was some fluid where he had stepped. He didn't even realize that that had happened.

Charcot arthropathy is another very serious injury that can happen with neuropathy. And there can be micro damage to the bones and joints, which then increases the blood flow to those fractured areas, and then overtime it just can get worst. This was a gentleman that had been helping his son move from a second-story apartment and he was carrying couches and refrigerators and all kinds of things up and down the stairs, and it ended up causing that damage. But then overtime, he didn't feel it and when they finally did come in and then take an X-ray, you can see the extent of damage that has happened in the mid foot area.

Also, autonomic nerve damage, which the skin becomes drier and the callus forms easier, fungus can start easier and there's cracks that can allow bacteria to lead to problems. Some of the symptoms of neuropathy, I'm sure you've heard many of those, but it can be varied. Again, when you think about the nerve being pinched or irritated, it's going to send out signals that maybe aren't really there but they're real feelings and can cause problems with patients.

Here's another example. We had a hard time figuring out what had happened. The patient had blisters on the top of his feet. Usually with neuropathy, we're seeing problems on the bottom or the sides from pressure. When it happened, he had worn boots that he hadn't worn in like five years. He wore them to a funeral and had ended up causing pressure on the top, but he just didn't feel it.

So, how do you prevent the neuropathy? We don't have any other answers besides controlling the blood glucose. That is what damages the nerves. Once that damage is there, you really can't go back. The damage is already done.

So now, we'll talk a little bit about arterial disease and what's causing that or what's happening there. This is an interesting photo. This is Southern California. Los Angeles would be right out in here. This is the Salton Sea. Our clinic area is about this area, if I circle that area. That is our clinic coverage area. This was back in 2004, it was called the Ring of Fire, and we're praying definitely for those that are up in Northern California now with the very serious, fires up there and loss of homes and lives. But what happened in 2004, you can see these mountains that surround Los Angeles. There are many fires and some of our tribes were displaced for a time. But what happened if you go up in the forest, this is the San Bernardino forest, national forest, it looks nice and green and it looks like you want to go out and take a hike and enjoy it. But if you look closer at the picture, some of the trees are brown, dead. There's one up here that's completely dead. And if you look at the forest floor, it's very dry this time of year and that is very similar to peripheral arterial disease.

Sometimes you might look at a foot and it looks okay, but all it takes is a spark, a cut or a pressure from the toenail pushing into the toe or something like that. At that point, the body just doesn't have the capacity to send down the nutrients and oxygen and the white blood cells that need to heal the wound or the damage to the body.

Really, it's the same process that you see in cardiovascular disease. That's the same process. It's just happening in the legs where there is damage and clogging of those arteries. Here's an example. Just a little pressure on the tip of the toe and the body just could not respond to that stress and the damage can spread. So we'll talk a little bit about screening for peripheral arterial disease a little bit later in the clinic. I just want to give you an idea as well, that there are more advanced things that are possible, ABI is one of those, arterial brachial index, and some Plethysmography wave forms. Our administration has been very supportive, and we bought a couple of these machines that do that wave form analysis. One of the podiatrists here reads those for referral. So, that has been very helpful as well for what you can do after the screening.

Then, how do you prevent the vascular disease? This is the same thing as preventing heart disease. Exercise, control cholesterol, smoking, controlling the blood pressure, those are all things that can help prevent that.

I wanted to talk just a little bit about ulcer and wound care too. Again, this will have to be very quick. Back in 2013, Dr. John Farris, from the Oklahoma area, gave a lecture on the IHS Grand Rounds and talked about their approach to wound care. Although, we have podiatrists on staff, there were still challenges that we had in providing what we felt would be the standard of care in wound care. So we talked with our administration, and again, they were supportive. We're actually in contact with John Farris in the Oklahoma Area Office. They set up a site visit where we were able to go to the Oklahoma City Indian Clinic and see how they did things. They were so good. They shared all kinds of material with us, paperwork and procedures and protocols and just other ideas of how they approach wound care. I know there are other very good sites throughout the United States that would welcome a site visit like that if that's something that your site would like to look into.

So, the way I look at an ulcer and wound care is really more about what you put on versus what you take off the wound. Here is a typical callus on the bottom of a diabetic foot and there's a danger sign there. There is some bruising, which means there has been enough pressure to damage the blood vessels underneath that callus. So that's a concern.

What do you take off the wound first? Non-healthy tissue, pressure and friction and drainage are some of the main things that you would want to remove from a wound. One of the challenging things with patients is sometimes, they'll come in with -- it looks like it's a closed wound, but underneath, you can see there's some bleeding. This was actually a very hard callus. You need to remove that pressure that is caused by the callus and you don't know what's underneath. Again, you have to talk with them and let them know that the bad things need to come off the wound, and they may leave with what looks like a worse wound that is actually going to heal much better.

Other things that when you're taking off total contact cast or other things that you can put into the shoe even that might help take pressure off of this area of foot where a callus is going to form.

What do you put on the wound? That's a much bigger topic because there are so many different products out there, dressings, topicals, but the idea is really to keep the wound in a moist environment and to decrease the bacterial burden there. I have another poll question I would like to ask everybody here, so you have picture one, picture two, and number three. From looking at those wounds, if you were an epithelial cell, where would you like to grow? Which wound would you like to be if you're going to try to help heal this wound? I agree with number three. There is good vascular tissue there and you have to realize as well, if you look at slide number one or photo number one, there's a lot of tissue and thick callus around that and kind of more like fibrous tissue that really isn't going to heal well. Number two is very dry and this is a challenge because patient will sometimes come and say, "Well, I just took off the dressing. I wanted to let it air out and dry." And really what's happening is the good cells on the top of that wound are desiccating or drying out and the epithelial cells are not going to be able to grow under that. So we'll go move on again. Thanks for your input and I'm glad everybody got that.

So as far as screening in the clinic, we had not been doing very well as far as our screening rates in our clinics and we are still working on that. We have a 49 close to 50% screening rate. So I had one of our IT people do a search for us, about how many of our diabetic registry patients have been to see a podiatrist during the past year and about half had. Really what that meant is that the foot screening was happening when they saw the podiatrist but it wasn't happening routinely. Again, this is screening. When we think of screening, we're thinking that is a primary care function and depending on the outcome of that screening exam, that is when you would decide to refer on to a specialist or not. So we knew we needed to go and then change how we approach things. So we are an IPC site. We sat down and started talking about some of those things. We put signs in the room that said it doesn't matter when you come in. You need to take off your shoes and socks if you are a diabetic. We did trainings in the nursing and provider staff meetings and also with our weekly care team meetings within the clinics. I will add that there is some very good training on the DDTP website on foot care and many other topics as well that nursing staff and other people can go to for that training as well.

For our site, we were having a hard time with our firewall for some reason so we actually did our own little video with one of the podiatrists here on how to do an appropriate foot screening within primary care. And with our community director Grant Fleming, we bought seven surface tablets that we will have those on. We haven't got them out to our different sites yet. So each site will have that for training, but we'll also put different patient educational items on that as well. So we hope that will help as new staff come in that they will be able to get the training and updated with that.

So part of that is regular feedback to the clinic, so here's an example. Again, there are seven clinic sites where we were keeping track of them over time of how they are doing with each separate clinic doing their foot screenings. For those of you that have RPMS/EHR, this is part of the training too, where do you find what the foot exam status is, which is both in the reminder tab and then also in the wellness tab, where you see other screens down in here where you can go and find out the status. Also in the diabetes supplement, which is something we try to have our own nursing staff printout for us as we go in to see a diabetic and it gives us more than just a foot exam and that's another place. And then how do you document whether that foot exam was done? Again, that's back in the wellness tab where you can document that foot actually counts and will show up in audits.

And then also, this is something with using iCare that has been very helpful to me. If you're going to do a PDSA or just a quick spot check of how a clinic is doing, what you can do is go into iCare and create just for -- I will usually do this at the end of the day after all the patients have been seen. You can create a panel just for that day. Once you have that panel formed, then you can go to the care management tab. If you go there, there are a couple of different things that will pop up here but pick diabetes and then you can actually go over and there's again a tab that shows their foot exam status. So you know if that has not been documented by the end of that, just that one day, you can go back to the care team and say, "Look, we did a check today and you did really good. You got eight out of eight or we missed a few and then you can look at some of the bottlenecks and what were some of the things that kept that from happening whether it was done and it wasn't documented or it was just a very busy day. So those are some things that I think have been helpful to me to be able to go in and give some feedback to the clinics on how they're doing.

Again looking at our audits, we started working on this last year a little bit and we increased, not as much as we would like, so we still have a lot of work to do going in and getting feedback to the clinics and doing training on how to get this accomplished routinely. Our hope is that if anytime a diabetic comes in, somebody checks and if it needs to be done, it will be done. It would be done for the rest of the year whenever they come in.

So going back again to the screening to prevent amputation. Again, this is a primary care approach. How can I help prevent amputation or identify patients that are at risk? Just a very basic screening

would be to do a visual exam within the skin and joints, checking their circulation, checking their nerve status and then also for deformities that again might cause problems or pressure in shoes.

One of the Three-Minute Foot Exam on the flyer also has risk stratification for what you should do depending on what you find out in the screening, and this is an example of that, so just foot care for all patients with diabetes. Every visit, they should take off their shoes and hopefully that's just expected. Now, that doesn't mean they get the whole screening but when the provider comes in, they can do a quick visual check and then beyond that an annual, at least once a year, a foot exam in the clinic. Referral when they find new or serious problems and then also patient education.

Now if a patient, you find out that they do have insensitive feet, then part of the education is they should be checking their feet. I know some people say, "Well, I heard that diabetics can't put their feet in water," and that's not so much that water is bad for diabetic feet, it's just that they should check the temperature of the water as they put that in. Dry feet between the toes, that's an area that doesn't evaporate the moisture there. Applying lotion and cream, again depending on the status of their skin but usually, I tell patients don't put that cream between the toes because it stays pretty moist there already, and then just proper shoes and socks, especially if they have insensitive feet.

And then special high risk patients -- so again insensitive feet at least every six months they should be having a full exam instead of just once a year. Now, if you include that with some other risk factors like a foot deformity, then do it a little bit more often. And then use a special shoe that has extra room in it for deformity as well. If you take somebody that has had foot ulcer amputation in the past, then they need to be coming in every two or three months and probably seeing the podiatrist or the specialist. Sometimes, there is even a custom-made shoe that will help protect that foot.

Again, just a basic primary care type of foot screening, a visual exam where you look at the skin, the legs, the ankles, the bottom of the feet, and in between the toes. It is important also looking at the toenails and if they're thick or ingrown. An example is what can happen if you don't look in between the toes. There could be a problem brewing there. Again, another example of very thick toenails and what happens is just on the edges, that thickening can cause pressure on the nail or become ingrown. An example of ingrown toenail obviously would need some care right away.

The other thing you're looking for is calluses and corns. Again, the thick skin sometimes is almost like strapping a little rock or pebble onto the bottom of the foot because it's hard and it causes increased pressure. One way I like to look at a callus is what caused this callus to form. If you look at your hands, I mean like mine, they're very soft and if I were to go out and get a pick and shovel and a hoe and start working, after a week or so, I would start to get a callus. The pressure and friction causes your body to respond to that and was trying to toughen it up on the bottom of a foot. Many times that becomes a problem because of that pressure and friction. A callus is really a red flag that this could be a problem area where damage could occur.

A corn is really just a small callus and sometimes deep. I don't know if you can see on the tip of these toes, there are little tiny calluses. Sometimes, these happen in between the toes as well but it's just in a place where there is a lot of pressure in one small spot. Again, those can be problems because there's going to be a lot of pressure that forms there.

An example, I think I showed this picture earlier, but this was a previous ulcer area underneath the big toe joint and so trimming the callus but then also looking at how are we going to take pressure off of that within the shoe. And they couldn't afford and we didn't have ability to give him better shoes other than that, so we just modified the shoes there and the inserts.

This is a corn. As you can see that it's kind of perfectly round about the shape of a corn pad and so medicated corn pads are not recommended in diabetics just for this reason. The acid can eat away at the good skin and not just the thick callus that is there. So I'm moving on then past just the visual look

over the foot, and again that should be like 30 seconds. You can look over the legs and ankles and feet and in between the toes very quickly. Pulses, you can feel those pulses. Capillary refill is a great test but you have to remember that the feet need to be above the heart. Otherwise, if you push and then we watch the blood come back, then that is just the venous blood returning for that, but that is another way to evaluate.

Again, when you're checking for the pulses, there are two main arteries that come down the foot. One is the dorsalis pedis and the other is the posterior tibial artery where you can find that pulse. Now, there are patients, where I can't feel a pulse, so that doesn't necessarily mean that there is a problem there. Most podiatrists will have a handheld Doppler within the clinic that can help in those if they can't feel. Again, we are very glad that our administration went on and helped us get some more advanced screening measures such as that as well. But if you can't feel a pulse and especially looking at the skin if it looks dry, then that may be a reason to go ahead and send them to a specialist for further evaluation.

Monofilament testing, this is primary care screening. There are other ways that you can check how the nerves are working, but one of the reasons why you pick a screening test is it's because you can do it in a widespread area with not too great of expense. So tuning fork is another one that can be done in the primary care. There are other things like what's called a biothesiometer that is a little machine that vibrates and you can adjust the vibration. Again, for screening, the monofilament is the standard of care.

Looking for deformities, I'll show you a couple of examples here of that, like a bunion. Again, you can look at this bunion, the right foot, where it's red, where that bunion is rubbing in a shoe. So that's going to be a foot we're concerned about. What type of shoe they're in, especially if this patient had neuropathy, that would be very high risk for that. Some other examples there, hammertoe. This is a patient that had a hallux amputation. When that happens, oftentimes the lesser toes will buckle even more from the pressure. Again, that's going to be a cause for concern in the shoe. Those deformities need to be noted in the notes as a possible risk factor, especially when you combine it with peripheral arterial disease or neuropathy.

So as far as some of the patient education, just basic things for their feet; stop smoking, check your feet every day. Especially with neuropathy, your feet are not going to be telling you what's wrong, so you need to check them. If your vision is poor, you sometimes need to look at the social factors with the patient, if they have somebody else that can help check their feet every day. Washing them daily, even in between the toes, not soaking the feet except just for a short time, and again checking the water for temperature, having somebody else check the water or check with the back of your hand or your elbow or something like that. Not going barefoot, that's a challenge for patients. Patients tell you, "My feet are claustrophobic in shoes and I've always gone without shoes." Some people say, "I don't wear shoes in the house, but I do when I go outside." The house can be a dangerous place with needles, pins, tacks, broken glass, all kinds of things like that too. So it's recommended again with people with a high risk foot, they're going to wear shoes protection even in the house; water bottles, heating pads and other things like that, we need to careful with, and chemicals, trimming your own corns for patients that are high risk. Every once and awhile we will see a patient that comes in and cuts their toenails too close and it wasn't painful, so they just kept going. And then, picking proper shoes and socks for patients.

Just briefly as well, I think most people are aware that there is a Medicare shoe benefit. Over recently, it has been a little bit harder sometimes to process some of the paperwork with that. But a lot of times, locally, there are providers that will offer shoe cares and you can refer them out to that. Here at our site, probably 10 years ago, we got support from our administration and they offered that even if a patient doesn't have that benefit for Medicare, they would cover those shoes. We try to follow the same guidelines as Medicare for whether they're eligible for those or not.

Another thing that is common within Native health and Native communities is the Nike Native. They are very good shoes. They cost about \$50 and our diabetes program has somebody that coordinates that. We don't do it within the clinic, but patients know they can come to the diabetes program and purchase shoes that could be helpful to them too. They're decently good shoes and not too expensive compared to what you might buy otherwise. So that is basically the end of my slides and I'd love to look at some of the questions that people might have had.

Jan Frederick:

Dr. Shumway, we want to thank you for your presentation. Kelli has been nice enough to gather up all the questions for us. So, can you see those on the right hand side of your screen?

Kendall Shumway:

Yeah. One of the first questions is, what is a non-traumatic LEA? LEA means lower extremity amputation, non-traumatic. People without diabetes, when does an amputation happen is when trauma such as an auto accident or work-related incident or something like that. So non-traumatic would be -- although, I guess in a diabetic, you might say there were some trauma that caused ulcer or something like that. But for a diabetic amputation, that would be a non-traumatic lower extremity amputation.

Another question, what types of socks are recommended for patients? Wool, cotton, mixed fibers. It's an interesting question because it used to be a lot of times I would hear people say, "Well, you should use white socks," which meant cotton and rather than a nylon or something like that. But even today, I have even see them in Walmart, socks that are diabetic socks that are made from synthetic fibers, but are very good at wicking away moisture better than cotton and some of the other things. So a lot of those diabetic socks would be some of the synthetic fibers. I can't remember some of them cool weave or I'd have to look that up to remember some of the fibers. But some of the synthetic fibers now are very good. So I don't recommend cotton. And again too, it's not white necessarily. So you don't have to get white socks if it's made from some of those other fibers.

Another question, as far as the ABI machines. Now, just doing an ABI within the clinic, you can do that with a Doppler probe and blood pressure cuff. The Doppler is probably \$400 to \$500, I would think. Now, the ones that do that and then graph it out, where they have waveforms, that is quite a bit more expensive. The ones we've got are close to \$10,000, and then we ended up getting two of those. Again, we are grateful for the support of our administration that saw the need and to do that type of testing.

Another question, where we can get the signs? The signs that we put up in the clinics actually came from the American Podiatric Medical Association. So if you put in APMA diabetic foot poster, then did a Google search, then you'd be able to find those categories.

Surface tablets - that is the Microsoft Surface. It's kind of like an iPad, only you can plug in like a thumb drive or something. So what we're doing is we're looking for are great educational videos from YouTube or whatever where you can download them. Sometimes, different drug companies will have different types of videos as well for patient education. So that's what we're putting some of those educational things including the educational things for nursing. I know nursing is planning on adding other thing besides that too, besides just foot exams. So, each of our clinics, each of our seven clinics will have one of those. The charge nurse would have it and then be able to -- if there's a new medical assistant or whatever that had just joined rather than taking time in one of the staff meetings to do it, then they could just watch that training video.

Another question, what would you say to a healthcare professional who advised a diabetic patient to leave their foot ulcer open to air for healing? Any advice on what is the best product for patients to use to clean a basin, they soak their feet in, that is also used by other family members that is affordable?

Well, for the healthcare professional, that is not correct. You should not leave a wound open to the air. Maybe get some articles. I don't know if there's a podiatrist on staff that they can talk with. I mean definitely, the literature supports wound care, keeping it covered and moist. As far as cleaning a basin, dilute bleach, I think would be appropriate for that, for cleaning the tub or the basin. You wouldn't want to use straight bleach, but a diluted solution with that would work well.

Another question, how much do you utilize for professionals, nursing assistant, and certified nursing assistants or RN in the basic monofilament screening? Here, we have been including them in that. We've done the training with them as far as even taking pulses, doing the monofilament, and then even documenting it. I guess with that poll, we've talked about the third answer was you just have too many other things you're discussing with the patient. And for it to happen routinely, the other para-professionals needs to be involved to make sure it happens. The doctor goes in and they're going to be hit with the many things that happen. Either that or the nursing takes the shoes off, so it's kind of expected. They have the monofilaments sitting right there. If the doctor wants to do that part of it, then the nurse can help get everything ready. So as the doctor walks in, the monofilament is sitting there on the stand, and the shoes are off, and they can do the exam very quickly.

Another question, screening aside from obvious reason, what is it considered abnormal? For each normal/abnormal selection of monofilament can attend what else is considered abnormal risk factors, fungus and calluses. Really for that foot exam, the monofilament and the circulation would be the two main things that would make it abnormal. Now, patients may have fungus or some calluses but that doesn't necessarily mean that they're going to be at a high risk for an ulcer formation, unless you combine it with those two things, the neuropathy.

Is it also good patient education to discourage clients from cutting off their own callus? Only pumice stone is recommended. Again, this comes down to risk factor. Well, any diabetic, I wouldn't recommend it to cut off their own calluses. Pumice stone would be fine as long as they don't have peripheral neuropathy or they have arterial disease. At that point, the patient should not be doing any type of callus, nail, that type of care on their own skin, that should go on to a specialist to handle that. But pumice stone, I think, is fine. If they can't feel, even with the pumice stone, they can go too deep, -- so that is not recommended.

I'll keep going on with the questions. Another question, what do you do with a toenail that has grown right into the top of the foot, no gap between the bed of the nail, a whole thing like a hard cap on the toe? That is sometimes where the skin can kind of come up over the top of the nail even at the very distal tip of the toe. It's possible they may need some anesthesia to numb up that area to really debride it well enough and remove the edge of the nail that's growing in. That is what my recommendation would be. Toenails can be very difficult, not hard. They can be very hard too, but they can be very difficult to trim. The right tools help with that and even sometimes anesthesia would be necessary.

Another question, how do you do the testing with the Doppler and blood pressure tests? What happens with that is when you're talking about an ABI, the ankle brachial index, and you're really doing the systolic blood pressure and comparing those two. So you're getting the ratio comparing the systolic blood pressure at your ankle with the systolic blood pressure at your arm. So what you do with the Doppler is listen for blood flow returning into the blood vessel distal to the cuff. So as you look there, you take the blood pressure cuff up to 200 or so, and then you start letting that out and you'd have the Doppler on the blood vessel listening for when the return of that blood flow comes, then you'd compare those two numbers with the ratio whether it's above or below one. And that would give you your risk levels for that.

Another question, why are foot soaks not recommended? Again, this is more about the temperature of the water, for diabetics. So, water is not going to damage your foot – foot soaking is just fine. If you do soak, then what I was referring to there would be for 5 to 10 minutes, just to soften up.

Another question, what do you think about coconut oil for preventing dryness on diabetic feet and also what do you think about Neosporin to help heal the ulcers on toes. The coconut oil, I think, is fine. I guess I've never used that. I don't think there's a problem with that for dryness. There are many products out there, but some of those can be very expensive too. A small tub or a small tube of a diabetic cream, but generally, I would recommend a cream more than a lotion. Those can be very expensive. Neosporin to help heal the ulcers on toes. Again, what you're looking at is keeping the burden down, the bacteria, but also keeping it moist, and Neosporin sometimes can do just fine with that. On toes, you're really gong to be worried about pressure and removing the pressure as well.