Comment

Male aged 58, with metabolic syndrome history, as well as level 2 obesity of abdominal predominance (BMI 37 kg/cm², abdominal circumference 101 cm), arterial hypertension, mixed dyslipidemia and T2D of more than 10 years of evolution, under combined treatment with premixed insulin aspart/aspart protamine 30/70 (0.69 IU/kg/day distributed in 2 doses) and oral agents (vildagliptine-metformin, 500/1.000 mg, 2 tablets per day). The metabolic control was usually inadequate (HbA1c of 10.5%) due to the lack of diet compliance. As known micro vascular complications of his diabetes, he showed diabetic nephropathy, non-proliferative retinopathy and erectile dysfunction, which have been treated finally with the implant of a penile prosthesis. As concomitant diseases, he showed a Barrett’s esophagus secondary to gastroesophageal reflux disease (GERD) and a sleep apnea-hypopnea syndrome (SAHS) under CPAP night treatment.

Clinically, the patient referred a progressive edematization of foot and left ankle of 6 months of evolution, with pain, dysesthesias like tingling with numbness and paresthesia of night predominance. He had no fever, or general condition affection. He did not refer previous traumatic lesions in the foot, or apparent tetanus as injuries or excoriations. He did not show either previous clinic of intermittent lameness or other symptomatology. In the clinical exploration, a hard edema could be observed in the foot and left ankle, up to the third part of the leg, with erythema and a discrete increase of local temperature, associated to a great deformity with loss of arch of the foot. He showed interdigital and bilateral nail mycosis, without any other lesions. The proprioceptive sensitivity explored with monofilament and calibrated tuning fork was clearly reduced bilaterally, with distribution “in sock”, though it was more intense in the left lower limb. Moreover, a reduction of the knecap osteotendinous reflex and Achilles heel in both legs could be observed. The peripheral pulses, back extensor digitorum brevis and tibial posterior muscles were palpable in the right foot, but were reduced in the left foot. The right ankle-arm index was normal (1.1) and it was not able to explore in the left lower limb due to the presence of edematization. The indicative biological parameters of inflammation were within normality (leukocytes 7.2 × 10³/µL with normal formula; hemoglobin 12.2 mg/dL; platelets 202 × 10³/µL, C-reactive protein 4.9 mg/dL; fibrinogen 4.1 mg/dL, ferritin 49 mg/dL).

In the x-ray of the left foot (figure 1), it could be stated the destruction of the joints between the wedges and the basis of the metatarsians, together with impairments in the head of the second and third metatarsians; findings that are compatible with the Charcot arthropathy, with predominance in the Lisfranc joint. Taking in account the symptomatology persistence, it was decided to perform a magnetic resonance imaging (MRI) of the foot in order to proceed with the differential diagnosis with osteomyelitis, notwithstanding that the clinical and biological data were not indicative of an infectious process.

The MRI showed a collapse of the foot vault with desestructuration of the mesofoot, inflammatory
changes with bone edema in the back foot and meso-foot bones and affection of the soft parts, compatible with the presence of osteomyelitis (figure 2). Considering the acute osteomyelitis diagnosis in diabetic foot, intravenous combined antibiotherapy was started with ciprofloxacin and clindamycin, together with foot discharge. The patient showed a favorable evolution with reduction of pain at rest and progressive reduction of the external inflammatory signs. After 3 months of treatment, the patient is asymptomatic, though a deformity in the back part of the foot still persists and certain difficulty for the flexo-extension of the ankle.