Considering the lessons from two illustrative cases: How to increase timely recognition of Charcot foot in practice

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In this issue, Roshan Siddique and colleagues (2026) present two illustrative cases of delayed diagnosis of Charcot neuroarthropathy (Charcot foot) in the UK. The authors highlighted the need for early clinical suspicion among health professionals, particularly medical professionals working in acute services.

Previously shared research in this journal demonstrated that podiatrists in Scotland routinely discuss Charcot foot 'danger signs' with individuals with a history of this condition (Bullen, et al, 2019). Podiatric consensus in Scotland is that patient education be considered for all at-risk individuals with diabetes-related peripheral neuropathy (DPN; Bullen et al, 2018).

Charcot foot can be effectively diagnosed by the podiatric workforce, triggering early immobilisation and multidisciplinary management. The cases presented by Siddique and colleagues (2026) demonstrate a lack of similar early recognition and immobilisation by medical colleagues in an English acute hospital setting. In fact, misdiagnosis may be considered the rule, rather than the exception, among non-specialist physicians (Chantelau, 2005; Schmidt, et al, 2017); and treatment delays averaged a comparable 10 weeks in a Danish study (Rasmussen, et al, 2018).

In their first case, a 58-year-old man presented to the emergency department (ED) with unilateral foot pain and difficulty with weight-bearing activity. A previous history of deep venous thrombosis (DVT) rightly raised suspicion of a subsequent thrombotic event and was excluded through ultrasonography. Plain foot radiographs were arranged and reported by the radiologist, who recommended repeat imaging and orthopaedic referral. Orthopaedic assessment after 1 month and a further acute medical unit presentation represented missed opportunities to commence offloading. In fact, 4 months passed before this individual received a Charcot diagnosis, based on MRI, and appropriate offloading.

The horse had officially bolted (Bullen, 2022), leaving this individual with an infected wound secondary to rocker-bottom foot deformity, despite prolonged immobilisation with total contact casts and a below-knee pneumatic walker.

Offloading simply had not been initiated soon enough and the outcome (trans-tibial amputation) was quite likely, given an ulcerated Charcot foot is associated with a 12-fold increased risk of major amputation (Sohn et al, 2010; La Fontaine et al, 2016).

The second case involved a 57-year-old man who also presented to the ED with unilateral foot pain and swelling. Again, DVT was excluded and, while orthopaedics initially suspected Charcot, and MRI was arranged, offloading did not commence until after Charcot was confirmed on MRI. Charcot diagnosis and immobilisation again only commenced three months after initial presentation to a healthcare setting. Despite 7 months of continued offloading, followed by community podiatry review, this man also experienced recurrent plantar ulceration.

Siddique and colleagues (2026) rightly highlighted that both cases illustrated the consequences of delayed diagnosis and offloading. Foot and ankle injuries are among the most common reasons for ED presentation; however, diabetes may be overlooked and assessment for DPN is rare (Peace et al, 2018). Peace and colleagues reported 56 of 1,191 (4.7%) individuals with lower-limb trauma presenting to a Scottish ED had diabetes; however, sensory testing was undertaken in only five out of 10 (50%) cases audited prior to an educational intervention. These authors demonstrated sensory testing among six out of six (100%) individuals with diabetes after 8 weeks of continued educational support; however, this fell to 60% on changeover of junior medical staff. Plain films were indeed actioned early, but it must be acknowledged that radiographic changes lag considerably from clinical signs.

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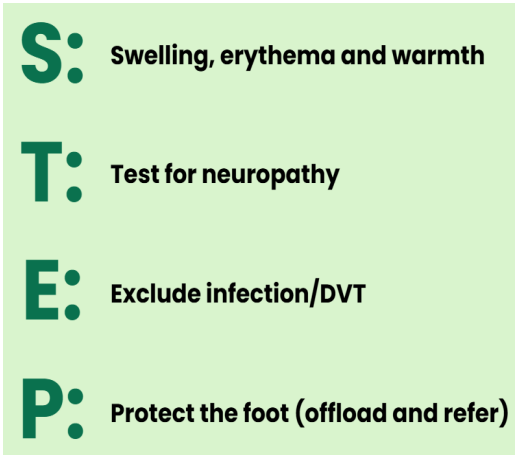


Figure 1. STEP acronym for Charcot neuroarthropathy.

For this reason, a high index of suspicion should remain if radiographic signs are not detected in an individual with DPN, presenting with an erythematous, hot and swollen foot.

Positioning podiatrists within the ED is pragmatic and may lead to increased timely recognition and effective management of Charcot foot. The 'STEP' acronym may be useful to keep Charcot foot at the forefront of clinician's minds and can be adapted for the ED and other clinical settings (*Figure 1*).

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