Appropriate footwear: sandals or shoes?

Susan Tulley

From the moment they are diagnosed with the condition, people with diabetes receive all kinds of advice – or at least they should – ideally from others with the condition or family members who are 'experts' in living with diabetes, and professional health-care providers. Of all of these recommendations, one that is often misinterpreted is that relating to 'appropriate footwear'. The key to this lies in the word 'appropriate'.

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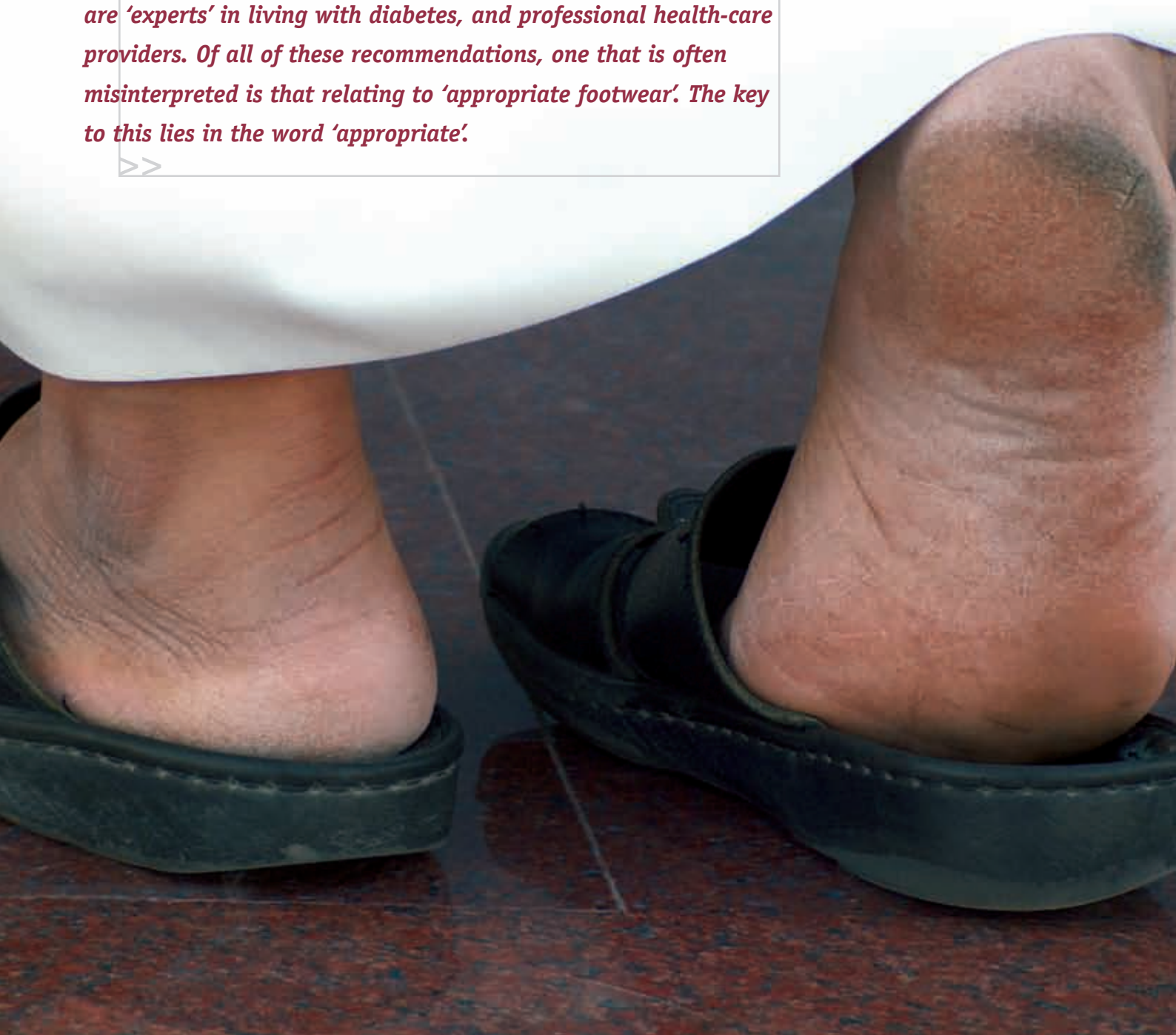

It should be remembered that many of the authors of articles on diabetes and footwear are based in countries which, as well as having decent podiatry services, have cold climates – predominantly the UK, northern Europe, and the USA. The recommended 'appropriate footwear' typically refers to a closed shoe that is made of soft leather – or something similar – with a flexible sole.

The term 'appropriate footwear' is often misinterpreted.

This advice can create problems for people reading diabetic foot literature who live in hot climates, such as in the Middle East and many other countries in the world where coincidentally there is often a higher prevalence of diabetes than in, say, northern Europe. In the Middle East, the prevalence of diabetes stands at around 26% of the population, rising to 40% in people over 60 years.

In such hot countries, advice on appropriate footwear is often understood to mean: *if you have diabetes, you must wear shoes*. Since this translates into *any shoe*, styles of footwear that would be considered inappropriate by a podiatrist – a hard, leather, slip-on shoe, for example, with a narrow toe – are often thought to be the correct protective choice. In fact, these shoes create problems with people's feet where none existed previously.

In the Middle East it is not common to see hard skin and corns on people's toes, or the nail problems caused by adverse pressure; people in the region traditionally wear open-toed sandals outside the house and often walk barefoot in the home. The foot problems that do occur are commonly related to the development of hard skin on the heels, which cracks with the heat and dust, or problems on the soles provoked by burns or contact with foreign bodies. All too often, people with impaired sensation in their feet due to diabetes nerve damage step barefoot onto hot concrete or sharp objects, such as thorns, outside the house or tread barefoot on household debris while at home.

In the Middle-Eastern countries, the heels of people's feet receive excessive exposure to the hot sun and dusty environment. Furthermore, poor-quality sandals are often to blame for foot problems: commonly, the heel of a person's foot, when treading down, overlaps the heel of the sandal. From a podiatry point of view, only a small percentage of people with diabetes in the Middle East need specially made shoes; better sandals are required for walking outside and encouragement to wear slippers at home.

A 'better sandal' means one with a flexible sole, adjustable fore-foot and mid-foot straps; and most importantly either a closed-in heel or a retaining strap that prevents the person's heel overlapping the edge of the sandal. You can see a good example on the front cover of this special issue. Additionally, for those people who require a cushioned insole, sandals with a recessed sole to accommodate an insole should be the footwear of choice.

We should encourage the use of sandals or slippers in the home.

'Appropriate footwear', in actual fact, should refer to footwear that is appropriate to the climate of the region – whether this means good sandals or good shoes. Let us not introduce the people with diabetes who live in hot climates to 'northern' foot problems! We need to improve sandals to reduce the incidence of conditions such as the Middle-Eastern heel problem; and encourage the use of sandals or slippers in the home to reduce the incidence of domestic injuries.

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