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Letter to Editor

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A dress does not fit everyone

Summary

Based on the recent opinion of Miranda and Da Ros about the patient education on foot care in order to prevent diabetic foot ulceration, in this "*Letter to the Editor*" we suggest that healthcare professionals, who handle the diabetic foot problems, should also take into account that, when compared to the white majority, some racial and ethnic minorities (that are increasing in Europe) have specific cultures, histories, languages, and characteristics that might have a different effect on their risk of diabetes mellitus, sensitivity to screening, response to treatment, and access to care. Therefore, initiatives and interventions that specifically target racial and ethnic minorities, as well as their peculiar characteristics, should be timely implemented into any therapeutic patient education for the prevention of diabetic foot. In a coming age of precision medicine, we have to acknowledge that a dress does not fit everyone and organize the patient education programs on foot care accordingly.

Keywords: diabetic foot, diabetic foot ulceration, therapeutic prevention program

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Introduction

We have read with interest the manuscript of Miranda and Da Ros, which was recently published in this Journal.[1] We completely agree with the Authors that education of the patient with diabetes mellitus regarding foot care is effective for the prevention of diabetic foot ulceration.[1–3] Importantly, this is even more evident when such education is structured, organized, repetitive, and combined with multiple preventive interventions.[1–3] However, we believe that another relevant (albeit not much acknowledged) aspect should be considered regarding this issue.

In Europe (and also in Italy), some racial and ethnic minorities (*e.g.,* black or Africans, Asian, Indians and Latinos) have a relatively larger burden of diabetes mellitus when compared to the white majority.[4] These include a higher prevalence of type 2 diabetes mellitus, lower rates of diagnosis, but also a higher rate of diabetic complications, including diabetic foot.[4] Importantly, the aforementioned racial and ethnic minorities have different cultures, histories, languages, and characteristics (*e.g*, biological, genetic and environmental) that might have an (adverse) effect on their risk of diabetes mellitus, sensitivity to screening, response to treatment, and access to care.[4]

We believe that, to date, all these relevant aspects should be always taken into consideration by the (multidisciplinary) foot care services when they handle the complex foot problems, in order to offer to everyone a fair and adequate medical service. Hence, initiatives and interventions (*e.g.,* cultural mediators, appropriate tools translated into different languages) that specifically target such racial and ethnic minorities, as well as their specific characteristics, should be timely implemented into any therapeutic education program for the prevention of diabetic foot. Importantly, the possibility to overwhelm any barrier, in order to obtain health equity for all individuals, will only be possible when we (as healthcare professionals) will acknowledge that racial and ethnic minorities are peculiar and, consequently, we will incorporate their differences in our everyday activities. In a coming age of precision medicine, we should recognize that a dress does not fit everyone, also when we organize the therapeutic patient education in the prevention of diabetic foot.

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Conflict of interest

The author declares that there is no conflict interest.

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