Social deprivation and incident diabetes-related foot disease in patients with type 2 diabetes

Riley, Jenny; Antza, Christina; Kempegowda, Punith; Subramanian, Anuradhaa; Chandan, Joht Singh; Gokhale, Krishna; Thomas, Neil; Sainsbury, Christopher; Tahrani, Abd A; Nirantharakumar, Krishnarajah

DOI:

[10.2337/dc20-1027](https://doi.org/10.2337/dc20-1027)

License:

None: All rights reserved

Document Version

Peer reviewed version

Citation for published version (Harvard):

Riley, J, Antza, C, Kempegowda, P, Subramanian, A, Chandan, JS, Gokhale, K, Thomas, N, Sainsbury, C, Tahrani, AA & Nirantharakumar, K 2021, 'Social deprivation and incident diabetes-related foot disease in patients with type 2 diabetes: a population-based cohort study', *Diabetes Care*, vol. 44, no. 3, pp. 731-739. <https://doi.org/10.2337/dc20-1027>

[Link to publication on Research at Birmingham portal](#)

General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

Social Deprivation and incident Diabetes-related Foot Disease in Patients with Type 2 Diabetes - A population-based Cohort Study

Short title: Deprivation and Diabetic Foot

Jenny Riley MSc¹, Christina Antza PhD^{2,3}, Punith Kempegowda MSc², Anuradhaa Subramanian MSc¹, Joht Singh Chandan PhD¹, Krishna Gokhale MSc¹, Neil Thomas PhD¹, Christopher Sainsbury¹, Abd A Tahrani PhD^{2,3,4*}, Krishnarajah Nirantharakumar MD^{1*}

*These authors share equal authorship.

¹ Institute of Applied Health Research, University of Birmingham, Birmingham, United Kingdom, B15 2TT

² Institute of Metabolism and Systems Research, University of Birmingham, Birmingham, United Kingdom.

³ Department of Diabetes and Endocrinology, University Hospitals NHS Foundation Trust, Birmingham, UK

⁴ Centre of Endocrinology Diabetes and Metabolism, Birmingham Health Partners, Birmingham, UK

Corresponding Author:

Dr Abd A Tahrani,

Institute of Metabolism and Systems Research,

University of Birmingham, Birmingham, UK.

e-mail: A.A.Tahrani@bham.ac.uk

Tel: +441214158705

Abstract:250, Word Count: 2931508, Number of figures: 1, Number of tables: 3,

References:4036

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Not Highlight

Abstract

Objective: To investigate the relationship between social deprivation and ~~development~~ ~~incident of~~ diabetes-related foot disease (DFD), in newly-diagnosed patients with type 2 diabetes ~~mellitus~~.

Research design and methods: A population-based, open retrospective cohort study, using The Health Improvement Network (~~THIN~~), ~~between~~ (01/01/2005 ~~and~~ 31/12/2019). Patients with type 2 diabetes, free of DFD at baseline, were stratified by the Townsend deprivation index and the risk of developing DFD was calculated. DFD was defined as a composite of foot ulcer (FU), Charcot arthropathy, lower limb amputation (LLA), peripheral neuropathy (PN), peripheral vascular disease (PVD) ~~and/or~~ gangrene.

Results: ~~179,870~~ 176,359 patients were eligible (~~565.9%~~ men; aged 62.9±13.1 years). After excluding 26,09444 patients with DFD before/within 15 months of type 2 diabetes diagnosis, DFD was incidentally developed in 12.08144% of study population during a median follow-up of 3.21 years (IQR:1.37-5.88) ~~years~~. Patients in the most deprived Townsend quintile had increased risk of DFD compared to those in the least deprived (aHR:1.224, 95%CI:1.165-1.297) after adjusting for sex, age at type 2 diabetes diagnosis, ethnicity, smoking, BMI, HbA1c, cardiovascular disease, hypertension, retinopathy, eGFR, insulin ~~treatment~~, glucose ~~lowering~~/lipid-lowering medications and baseline foot risk. Patients ~~at in~~ the most deprived Townsend quintile had higher risk of ~~peripheral neuropathy PN~~ (aHR:1.187, 95%-CI:1.110-1.254), ~~FU foot ulceration~~ (aHR:1.4428, 95%CI:1.171-1.7748), PVD (aHR:1.4039, 95%CI:1.287-1.532) ~~and~~ LLA (aHR:1.75, 95%CI:1.08-2.834) and gangrene (aHR:8.49, 95%-CI: 1.01-71.58) compared to those in the least ~~deprived~~.

Conclusion: Social deprivation is an independent risk factor for the development of DFD, PN, FU foot ulceration, PVD, and LLA and gangrene in ~~newly diagnosed~~ newly-diagnosed patients with type 2 diabetes. Considering the high individual and economic burden of DFD,

strategies targeting patients in socially deprived areas are needed ~~to and will~~ reduce health inequalities.

Key words: Type 2 diabetes mellitus, diabetic foot disease, deprivation, Townsend index, foot ulcer, peripheral vascular disease, amputation

Abbreviations:

DFD: Diabetic Foot Disease, **DFU:** Diabetes-related Foot Ulceration, **DPN:** Diabetes Peripheral Neuropathy, **LLA:** Lower Limb Amputation, **PVD:** Peripheral Vascular Disease, **CV:** Cardiovascular, **THIN:** The Health Improvement Network, **BMI:** Body Mass Index, **eGFR:** estimated Glomerular Filtration Rate, **HA1c:** Haemoglobin A1c, **SD:** Standard Deviation, **IQR:** Interquartile Range, **aHR:** adjusted Hazard Ratio, **OR:** Odds Ratio

1. Introduction

Diabetes mellitus is a major public health challenge, affecting more than 400 million people worldwide. (1) In the UK, an estimated £14 billion is spent a year on treating diabetes, driven by the cost of treating ~~the~~ diabetes-related complications. (2)

The global prevalence of diabetes-related foot diseases (DFD) is estimated to be 6.3% and it is one of the most expensive complications of diabetes mellitus. (3; 4) The lifetime incidence of diabetes-related foot ulceration (DFU) is 19-34%, while Lower limb amputation (LLA) incidence rate in diabetes is 2.51 per 1,000 person-years and the prevalence of diabetes peripheral neuropathy (DPN) is 50%. (5-8) DFU and LLA are associated with significant disability (9) and increased mortality (5 year mortality risk: 70% following LLA and 50% following DFU). (10)

Diabetes peripheral neuropathy (DPN), and peripheral vascular disease (PVD) are major contributors to the development of DFD, DFU and LLA. (11) Current preventative strategies are focussed on preventing PVD and DPN by improving glycaemic control and cardiovascular (CV) risk factors and providing appropriate education and foot-wear to patients. (12) These have resulted in reduction in the risk of LLA (12) but DFD remains common and hence better understanding of the risk factors is needed.

Social deprivation is a potential contributor to the risk of DFD as it is associated with obesity and CV risk and development of type 2 diabetes. (13-19) Hence, we hypothesised that social deprivation is a risk factor for DFD in patients with type 2 diabetes.

To examine our hypothesis, we conducted a large population-based cohort study, using a UK nationally representative primary care database, aimed at examining the relationship between social deprivation and the incidence of DFD.

2. Research design and methods

Formatted: Indent: Left: 1.27 cm,
No bullets or numbering

Formatted: Font: (Default) Times
New Roman, Bold

Formatted: Normal, Indent: Left:
0.75 cm, No bullets or numbering

2.1 Design of the study

A population-based, open retrospective cohort study, using routinely collected data from The Health Improvement Network (THIN) database between the 1st January 2005 and the 31st December 2019.

2.2 Data source: The Health Improvement Network

THIN consists of anonymised primary care records taken from over 800 UK general practices. The database is largely representative of the UK population in terms of demographics and morbidity prevalence. (20) The dataset consists of symptoms, examinations and diagnoses which are recorded using a hierarchical coding system called Read codes. (21; 22)

2.3 Study population, inclusion and exclusion criteria in the exposed cohort

All patients were recruited from practices that have been using the vision electronic system for 1 year and had acceptable mortality reporting. Patients were eligible to join the exposed cohort if they developed type 2 diabetes (based on Read codes) during ~~the~~ follow-up (Supplementary File 1). Patients with ~~a coded diagnoses of type 1 diabetes~~ coded diagnosis of type 1 diabetes were excluded. Furthermore, patients with age at diagnosis below the age of 30 with a record of insulin prescription and no prescription record of any of the oral diabetes medications in their medical history were excluded, as they were considered to be potentially misclassified as type 2 diabetes. Patients who already have one of the outcomes of interest at baseline or those who developed them between diagnosis date and index date (i.e. 15 months after type 2 diabetes diagnosis) were excluded from the ~~longitudinal~~ incident analysis. The latency period provides a 15th month window of opportunity for assessment of baseline foot risk and documentation of diabetes related covariates.

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 1.5 cm, No bullets or numbering

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 1.75 cm, No bullets or numbering

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 2.5 cm, No bullets or numbering

The exposed cohort was subcategorised by Townsend deprivation score, which is the independent exposure variable in this study. The Townsend score is a measure of material deprivation developed in 1988, from census tables. (23) It includes unemployment, overcrowding, car ownership and home ownership for small geographies, which are z-scored to produce an overall score. This is the deprivation marker included in primary care records, derived from a patients' postcode. Townsend score is already recorded in THIN database as quintiles, with the 1st quintile to be the lowest (least deprived) and the 5th the highest.

2.4 Outcomes and co-variables

The primary outcome of the study was the incident diagnosis-subsequent recording of DFD (a composite outcome of DFU, PVD, DPN, Charcot arthropathy, LLA and gangrene).

Co-variables include age at type 2 diabetes diagnosis, sex, ethnicity, body mass index (BMI), smoking, glucose lowering treatment, lipid lowering medication, insulin treatment as a proxy for diabetes disease severity, estimated glomerular filtration rate (eGFR), haemoglobin A1c (HA1c), retinopathy, hypertension, CV disease and baseline foot risk score. Baseline foot risk coded from the relevant Read codes was categorised as 1) low risk (normal sensation, palpable pulses), 2) increased risk/moderate risk ~~increased risk~~ (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer), 4) non-attendance of foot examination, or 5) missing foot risk data ([Supplementary File 1](#)). (24) Primary care practitioners insert the foot risk score as per their contractual agreement into the electronic system in the form of Read codes. Primary care practitioners insert the foot risk score into the electronic system in the form of Read codes. In this study, we used these codes as they were presented in the THIN database and we have not recoded the foot score based on other information available in the database.

2.5 Follow up period

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 2.75 cm, No bullets or numbering

Formatted: Font: (Default) Times New Roman

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 3 cm, No bullets or numbering

The follow-up period began from the index date (15 months after type 2 diabetes diagnosis) until the patient exit date (the earliest date of either the outcome of interest, patient transferred to another practice, the final data collection date from their general practice or death).

2.6 Ethical approval

The THIN data collection scheme received multicentre research ethics committee (MREC) approval in 2003, and for this particular study, with the Scientific Review Committee approval (SRC Reference Number: 18THIN090) was obtained of this particular study in December 2018.

2.6 Statistical analysis

Continuous variables were presented as mean, ± standard deviation (SD) or median, interquartile range (IQR) depending on their distribution. Binary and categorical variables were analysed presented as frequencies and percentages.

Data cleaning and analysis was done using STATA 16.2. A Cox proportional hazards model was used to calculate crude and adjusted hazard ratio (aHR) of the composite DFD, and individual components of the composite outcome among patients in each of the Townsend deprivation quintile compared to those in the 1st quintile (least deprived), where numbers of outcomes were sufficient in each Townsend deprivation category. The proportional hazards assumption was checked using log-log plots. At cohort entry, using a logistic regression model, we calculated the odds ratio (OR) of DFD diagnosis before or within 15 months of diabetes diagnosis comparing among patients from each Townsend category deprivation quintile compared to those in the 1st quintile.

All effect sizes (HRs and ORs) were calculated along with 95% confidence interval. A p-value <0.05 was considered statistically significant.

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 1.75 cm, No bullets or numbering

3. Results

3.1 Study population characteristics

The baseline characteristics of patients ~~within the cohort~~ with a coded diagnosis of type 2 diabetes ~~and after the application of exclusion criteria of those considered as potentially misclassified~~ are summarized in ~~Table 1 stratified by Townsend quintiles. There were~~ Of the 1796,359,870 patients ~~meeting the inclusion criteria with a diagnosis of type 2 diabetes within~~ ~~THH~~ included in our study, there were 31,732 (18.0%), 30,655 (17.4%), 324,021 (18.2%), 29,984 (17.0%), 22,881 (13.0%) patients from Townsend quintile 1 to 5, with 29,086 (10.8%) patients have a missing record of Townsend deprivation quintile.

565.90% of the total cohort were male and the mean age ~~of diagnosis at cohort entry~~ was 62.849 (SD± 13.1324) years ~~old~~; Patients from the most deprived quintile were younger at study entry compared to the least deprived [61.8360.64 (SD 13.5830) vs 64.52 (SD 12.26)]. The majority of ~~included~~ patients had obesity (53.1%), and were ex (36.2%) or non-smokers (47.38%). ~~Patients from the most deprived quintile were more likely to have obesity at baseline and were more likely to be current smokers compared to those from the least deprived (Obesity: 58.944.0% vs 46.7%; Current smokers: 25.7% vs 9.8%) HbA1c was recorded in 96.0% of the study participants, with a mean HbA1c value of 59.4357 (SD 22.43744) mmol/mol. Patients from the most deprived quintile were more likely to have a record of HbA1c > 69.4 mmol/mol at baseline compared to those from the least deprived (23.4% vs 20.5%). Ethnic minority patients were more likely to be from the highest deprivation quintile compared to the lowest deprivation quintile (8.9% vs 2.9%). Patients from the most deprived quintile were more likely to have a record of HbA1c > 69.4 mmol/mol at baseline compared to those from the least deprived (23.4% vs 20.5%). Over a third of patients (32.6%) had HbA1c ≤ 47.5 mmol/mol (≤ 6.5%), while Nearly half of the participants~~

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 0.75 cm, No bullets or numbering

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 1.75 cm, No bullets or numbering

had hypertension (54.64%), and a quarter had CV disease (23.32%) at baseline. Patients were approximately equally distributed across the first four Townsend quintiles, though there were less in the most deprived quintile.

Patients in the most deprived quintile had the highest percentages of smoking, obesity, moderate and high foot risk score at baseline (2.0% vs 1.2%), lipid drugs and insulin treatment (2.9% vs 2.0%), poorer glycaemic control and end stage kidney disease (0.9% vs 0.7%) at baseline compared to those from the least deprived quintile.

~~3.2 Odds ratio of having DFD at baseline amongst the five deprivation scores~~

Social deprivation and the baseline odds of DFD

A total number of 26,094 (14.8%) 440 patients had a recording of DFD before the index date (either before diabetes diagnosis, or during the 15-month latency between diagnosis date and the index date). The greatest percentage of patients with pre-existing DFD were those in the lowest deprivation quintile: 1st qQuintile (14.0%; 4,437/31,752), 2nd qQuintile (14.9%; 4,554/30,672), 3rd qQuintile (15.3%; 4,911/32,041), 4th qQuintile (15.7%; 4,721/30,022), 5th qQuintile (16.7%; 3,832/22,921) and missing Townsend data (12.5%; 3,645/29,117).

~~These patients were excluded from the longitudinal analysis. However, a separate analysis for the association of social deprivation and early onset of DFD was done. After adjustment for all the covariates~~ Following adjustment of variables highlighted in the methods section mentioned (except baseline foot risk score (due to potential collinearity with baseline foot disease), all Townsend deprivations quintiles scores were associated with a higher adjusted odds ratio of having DFD at index date, having as reference when compared to the those in least deprived quintile score (i.e. Townsend deprivation quintile 1) The results show increasing odds of DFD at baseline with increased deprivation score: qQuintile 2; (aOR

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 1.5 cm, No bullets or numbering

1.04; 95% CI 1.00-1.09, [qQuintile 3](#); -aOR 1.143; 95% CI 1.098-1.19, [qQuintile 4](#); aOR 1.18; 95% CI 1.13-1.24 and [qQuintile 5](#); aOR 1.345; 95% CI 1.28-1.41 ~~for quintiles 2,3,4 and 5 respectively, p<0.05 for all.~~ Further details can be found in [sSupplementary File 2](#). ~~The results show a social gradient with the increasing odds of DFD at baseline to be increased with each increase in quintile with increased deprivation score.~~ There was a slightly lower [adjusted](#) odds of ~~baseline foot disease~~ DFD recorded at baseline among those with a missing recording of Townsend (aOR: 0.95; 95% CI 0.91-1.00).

3.3 Social deprivation and the [incident](#) risk of DFD

~~These Ppatients with pre-existing DFD at baseline (14.8%; 26,100/176,525) were then excluded from the longitudinal incident analysis. However, a separate analysis for the association of social deprivation and early onset of DFD was done.~~ From the eligible patients of the study ~~Out of the 150,265 patients followed up, 18,153 (12,081 14%) developed DFD during a median follow-up of 3,273 21years (IQR 1.41-5.96) years follow up.~~ The incidence rate (per 1,000 person years; 95% CI) of developing DFD ~~was highest in patients in the lowest Townsend quintile;~~ increased with increasing deprivation; [quintile 1; 29.8 \(28.8-30.8\), quintile 2; 31.24 \(30.1-32.3\), quintile 3; 30.45 \(29.4-31.5\), quintile 4; 31.7 \(30.6-32.8\), quintile 5; 324.89 \(33.5-36.2\).](#) Following adjustment this translated into a statistically significant increased risk of developing DFD in Quintiles 4 (aHR 1.10 (95% CI 1.04-1.15)) and 5 (aHR 1.22 (95% CI 1.16-1.29)). ~~There was a stepwise increase in the risk of DFD with worsening deprivation between quintiles 2 and 5 compared to quintile 1~~ Further details can be seen in ~~(t~~Table 2).

[Of the types of DFD, the most common outcome during the follow up was DPN \(8.9%\).](#) The incidence of the individual components of the composite DFD outcomes ([DPN](#), [DFU](#), [PVD](#), [LLA](#), [Charcot arthropathy](#) and [gangrene](#)) in the different [quintiles](#) of Townsend score is summarised in [table 31](#) and ~~t~~Figure 1.

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Most notably, patients living in the most deprived Townsend quintile (5) have went on to have a statistically significant higher-increased risk of developing DPN (aHR: 1.187, 95% CI 1.110-1.254), DFU (aHR 1.4428, 95% CI: 1.174-1.7748), PVD (aHR 1.4039, 95% CI: 1.287-1.532) and LLA (aHR 1.75, 95% CI: 1.08-2.834) and gangrene (aHR: 8.49, 95% CI: 1.01-71.58) compared to patients living in the least deprived (1). The incidence of Charcot arthropathy (aHR 1.78, 95% CI: 0.83-3.86) and gangrene (aHR 5.62, 95% CI: 0.60-52.87), although seems to be more increased in higher among those in the most deprived Townsend quintile, but the result-increase in risk was not statistically significant (aHR 1.65, 95% CI: 0.78-3.49). Details are provided in Table 3.

3.4 Risk factors of DFD from the fully adjusted model

The relationship of other covariates and incident DFD

Details about the adjusted hazard ratios of the exposure Townsend deprivation quintile and the included covariates in the fully adjusted cox regression model are presented in Supplementary File 3. In the final adjusted model for incident risk of DFD, the following covariates emerged as risk factors in addition to social deprivation: higher age [aHR (1.03; 95% C 1.03-1.04)], male sex [aHR (0.86, 95% CI: 0.84-0.89) for women compared to men], Caucasian ethnicity [compared to Caucasian ethnicity, aHR (0.78, 95% CI: 0.62-0.97) for mixed race, (0.84, 95% CI: 0.59-1.19) for Chinese/Middle Eastern/others, (0.63, 95% CI: 0.53-0.74) for Black African-Caribbean, and (0.71, 95% CI: 0.64-0.79) for South Asian], obesity [aHR (1.17, 95% CI: 1.11-1.22)], ex and current-smoking status [compared to non-smokers, aHR (1.10, 95% CI: 1.06-1.14) and (1.33, 95% CI: 1.27-1.39) respectively], poor glycaemic control [compared to those with HbA1c <47.5 mmol/mol, aHR (1.10, 95% CI: 1.04-1.16) and (1.19, 95% CI 1.14-1.25) among those with HbA1c between 58.5 and 69.4

mmol/mol and HbA1c > 69.4mmol/mol respectively], lower glomerular filtration rate [compared to those with eGFR > 60 ml/min/1.73m², aHR (1.14, 95% CI: 1.09-1.19) among those with eGFR between 30 and 60 ml/min/1.73m²], higher foot risk score or non-recording or decline of foot risk exam [compared to those with low foot risk, aHR (1.61, 95% CI: 1.51-1.73) among patients with moderate~~medium~~ foot risk score, (2.73, 95% CI: 2.34-3.19) among patients with high foot risk score, (1.51, 95% CI: 1.23-1.85) among those who declined foot examination and (2.00, 95% CI: 1.93-2.07) among those with missing foot risk score], concurrent diagnosis of CVD [aHR (1.23, 95% CI: 1.19-1.28)], hypertension [aHR (1.03, 95% CI: 1.00-1.07)], sight threatening retinopathy [aHR (1.14, 95% CI: 1.08-1.19) and prescription of glucose lowering medication [aHR (1.13, 95% CI: 1.09-1.16)] and insulin treatment [aHR (1.36, 95% CI: 1.24-1.50)].

including all covariates, for every year increase in the age of type 2 diabetes diagnosis, the risk of DFD increases by 3%. The risk of DFD was lower in females, and non white ethnicity.

Obesity was found not to be a significant predictor (aHR 1.07; 95% CI 0.87-1.31). Current or ex-smoking (aHR: 1.31; 95% CI 1.26-1.37 and 1.10; 95% CI 1.06-1.13, poor glycaemic control (aHR: 1.20; 95% CI: 0.15-1.25), hypertension (aHR 1.04; 95% CI 1.01-1.08), retinopathy (aHR 1.14; 95% CI 1.08-1.19), CV disease (aHR 1.23; 95% CI 1.19-1.28), and the use of insulin (aHR 1.37; 95% CI 1.25-1.50) were independent predictors of incident DFD.

Baseline foot risk classification showed the largest effect among the covariates. Unsurprisingly, patients with the highest baseline foot risk had over two and a half times higher the risk of DFD at any time during follow up (aHR 2.64; 95% CI 2.27-3.08). Details about the covariates of the full cox regression model are presented in **Supplementary File 3.**

4. Discussion

We found that social deprivation was a risk factor for the development of DFD, DPN, DFU, PVD, ~~and~~ LLA and gangrene in patients newly diagnosed with type 2 diabetes. The findings remained significant despite adjustment for many important covariates including sex, age ~~at diagnosis type 2 diabetes~~, ethnicity, smoking status, BMI, HbA1c, CV disease, hypertension, retinopathy, eGFR, insulin or other prescribed diabetes medications, lipid lowering medications, and foot risk score at baseline.

Other studies examined the relationship between DFD and social deprivation. (25-28) Our results are consistent with other studies from the UK, and add to their findings. Two UK studies included more than 10,000 participants each, found that deprivation was associated with either increased risk of DFU or mortality after DFU. (26; 29) However, these studies were either cross-sectional (25); included patients with both type 1 and 2 diabetes (25; 26), focused on foot ulcer (27) or were based on regional data. ~~(27)~~ (28) Our study specifically looked at patients with newly diagnosed type 2 diabetes, used a database that covers multiple regions in England, was retrospective cohort by design and examined a wide range of DFD outcomes. ~~Thus~~ Thus, our study adds novel insights to previously published literature.

Many of the studies that examined the relationship between social deprivation and DFD did not adjust for ethnicity. Adjusting for ethnicity is important considering the South Asians have been shown previously to show lower risk of DFU, LLA and DPN compared to White Europeans with type 2 diabetes. (30-32) Our findings are consistent with these studies that non White ethnicity had lower DFD risk; but we expand that as the relationship between social deprivation and DFD was independent of ethnicity in our analysis.

Not all previous studies showed a relationship between DFD and social deprivations. One study, from North-West England, did not show an association between socioeconomic status and new foot ulcers in adults with type 1 and type 2 diabetes, (27) but in this study the

Formatted: Font: (Default) Times New Roman, Bold

Formatted: Normal, Indent: Left: 1 cm, No bullets or numbering

Formatted: Font: (Default) Times New Roman

follow-up duration was shorter than our study (2 years) and did not exclude patients with DFU at baseline. Three other studies from outside the UK found no association between socioeconomic factors and infection, amputation or DFD, but these studies were small and potentially under powered (n=572, n=112, n=102). (33-35)

Our results are important as they identify a population at an increased risk of developing DPN, DFD, DFU, ~~and~~ LLA, and gangrene. Hence, by focussing on screening as a preventative strategy on high risk population we could reduce the health and economic burden of DFD, type 2 diabetes and reduce health inequalities.

The effect sizes reported in this study for the association between social deprivation and DFD are modest. This reflects the multifactorial nature of the development of DFD, where multiple other DFD risk factors were also identified in our study with similar modest effect sizes such as obesity, CVD, smoking and poor glycaemic control. In addition, identifying social deprivation as a ~~high-risk~~high-risk population for DFD is likely to be beneficial for a wider range of DFD risk factors considering the established links between DFD and obesity and CVD (ref)."(36)

Our findings showed that having a high foot risk score (which is defined based on multiple clinical parameters) had the largest effect size in terms of predicting DFD. This is consistent with previous study that showed using a combined risk score/tests had better sensitivity than using individual tests in predicting the development of DFD. (37)

The results of the present study should be interpreted within the context of the study limitations and strengths. One possible limitation is that the use of routinely collected primary care data may lack ~~of~~ accuracy and completeness of recording. However, THIN has been shown to be representative to the UK population in terms of mortality and major chronic diseases. (20; 38; 39) Another possible limitation is the possibility of delayed type 2 diabetes

Formatted: English (U.S.)

diagnosis in the deprived quintile, thereby a more severe diabetes cohort among the deprived subgroups. However, a latency period of 15 months provides sufficient time to record for proxy covariates that indicate diabetes severity such as insulin prescription, HbA1c measurement, concurrent macrovascular complications such as retinopathy and nephropathy.

These covariates are adjusted for in our analysis. [Another limitation is the large proportion of missing ethnicity missing data. However, we have used a missing ethnicity category in the multivariable analysis to minimise the impact of missing data in this variable. Reassuringly, our analysis showed that South Asians and Black Afro-Caribbeans had lower risk of incident DFD compared to White Caucasians, which is consistent with previous studies \(Ref\)](#) (30; 32; 40) This is the largest, population-based study, representative of the UK population, study to-date that has examined the impact of deprivation on DFD, and reported outcomes other than DFU and LLA. The large sample size also allowed us to adjust for many biologically important covariates.

In conclusion, deprivation is a risk factor of DFD, DPN, DFU, PVD, LLA, and gangrene in patients newly diagnosed with type 2 diabetes. Screening and preventative strategies targeting this [high-riskhigh-risk](#) population could reduce the economic and health burden of type 2 diabetes and reduce inequalities.

Acknowledgements:

Author contributions:

JR: Organise and conduct the study.

CA: Interpretation of the results, proposed the structure of the paper, formulated the paper.

PK, AS, JSC: Interpretation of the results, statistical analysis.

KG, NT, CS: Critically appraised the paper, make the final suggestions.

AAT, KN: Proposed the idea, critically appraised the paper, make the final suggestions.

All authors reviewed and revised the manuscript and agreed to submission of the final manuscript.

Statement of assistance: None

Guarantor's name: Dr Abd A Tahrani

Prior publication of the study in abstract form: No

Funding/Financial support: None

Conflict of interest: All authors have no relevant conflicts of interest to disclose.

Transparency declaration:

The lead author (the manuscript's guarantor) affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

References

1. World Health Organization. Diabetes. [article online], 2018. Available from <https://www.who.int/news-room/fact-sheets/detail/diabetes>.
2. Cost of Diabetes [article online], 2019. Available from <https://www.diabetes.co.uk/cost-of-diabetes.html>.
3. Tcherro H, Kangambega P, Lin L, Mukisi-Mukaza M, Brunet-Houdard S, Briatte C, Retali GR, Rusch E. Cost of diabetic foot in France, Spain, Italy, Germany and United Kingdom: A systematic review. *Annales d'endocrinologie* 2018;79:67-74
4. Zhang P, Lu J, Jing Y, Tang S, Zhu D, Bi Y. Global epidemiology of diabetic foot ulceration: a systematic review and meta-analysis (†). *Annals of medicine* 2017;49:106-116
5. Armstrong DG, Boulton AJM, Bus SA. Diabetic Foot Ulcers and Their Recurrence. *The New England journal of medicine* 2017;376:2367-2375
6. Kucera T, Shaikh HH, Sponer P. Charcot Neuropathic Arthropathy of the Foot: A Literature Review and Single-Center Experience. 2016;2016:3207043
7. Lee CC, Perkins BA, Kayaniyl S, Harris SB, Retnakaran R, Gerstein HC, Zinman B, Hanley AJ. Peripheral Neuropathy and Nerve Dysfunction in Individuals at High Risk for Type 2 Diabetes: The PROMISE Cohort. *Diabetes care* 2015;38:793-800
8. Holman N, Young RJ, Jeffcoate WJ. Variation in the recorded incidence of amputation of the lower limb in England. *Diabetologia* 2012;55:1919-1925
9. Vileikyte L. Diabetic foot ulcers: a quality of life issue. *Diabetes/metabolism research and reviews* 2001;17:246-249
10. Fortington LV, Geertzen JH, van Netten JJ, Postema K, Rommers GM, Dijkstra PU. Short and long term mortality rates after a lower limb amputation. *European journal of vascular and endovascular surgery : the official journal of the European Society for Vascular Surgery* 2013;46:124-131
11. Boulton AJ. The diabetic foot: grand overview, epidemiology and pathogenesis. *Diabetes/metabolism research and reviews* 2008;24 Suppl 1:S3-6
12. Gregg EW, Li Y, Wang J, Burrows NR, Ali MK, Rolka D, Williams DE, Geiss L. Changes in diabetes-related complications in the United States, 1990-2010. *The New England journal of medicine* 2014;370:1514-1523
13. Armstrong DG, Fisher TK, Lepow B, White ML, Mills JL. Pathophysiology and Principles of Management of the Diabetic Foot. In *Mechanisms of Vascular Disease: A Reference Book for Vascular Specialists* Fitridge R, Thompson M, Eds. Adelaide (AU), University of Adelaide Press, 2011
14. Rose G, Marmot MG. Social class and coronary heart disease. *British heart journal* 1981;45:13-19
15. Matthews KA, Kelsey SF, Meilahn EN, Kuller LH, Wing RR. Educational attainment and behavioral and biologic risk factors for coronary heart disease in middle-aged women. *American journal of epidemiology* 1989;129:1132-1144
16. Volaco A, Cavalcanti AM, Filho RP, Precoma DB. Socioeconomic Status: The Missing Link Between Obesity and Diabetes Mellitus? *Current diabetes reviews* 2018;14:321-326
17. Connolly V, Unwin N, Sherriff P, Bilous R, Kelly W. Diabetes prevalence and socioeconomic status: a population based study showing increased prevalence of type 2 diabetes mellitus in deprived areas. *Journal of epidemiology and community health* 2000;54:173-177

18. Everson SA, Maty SC, Lynch JW, Kaplan GA. Epidemiologic evidence for the relation between socioeconomic status and depression, obesity, and diabetes. *Journal of psychosomatic research* 2002;53:891-895
19. Evans JM, Newton RW, Ruta DA, MacDonald TM, Morris AD. Socio-economic status, obesity and prevalence of Type 1 and Type 2 diabetes mellitus. *Diabetic medicine : a journal of the British Diabetic Association* 2000;17:478-480
20. Blak BT, Thompson M, Dattani H, Bourke A. Generalisability of The Health Improvement Network (THIN) database: demographics, chronic disease prevalence and mortality rates. *Inform Prim Care* 2011;19:251-255
21. Booth N. What are the Read Codes? *Health Libraries Review* 1994;11:177-182
22. Gokhale KM, Chandan JS, Toulis K, Gkoutos G, Tino P, Nirantharakumar K. Data extraction for epidemiological research (DExtER): a novel tool for automated clinical epidemiology studies. *European Journal of Epidemiology* 2020;
23. Townsend P, Phillimore, P. and Beattie, A. *Health and Deprivation: Inequality and the North*. Routledge, London 1988;
24. British Medical Association. 2019/20 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF). . 2019
25. Skrepnek GH, Mills JL, Sr., Armstrong DG. A Diabetic Emergency One Million Feet Long: Disparities and Burdens of Illness among Diabetic Foot Ulcer Cases within Emergency Departments in the United States, 2006-2010. *PloS one* 2015;10:e0134914
26. Anderson SG, Shoo H, Saluja S, Anderson CD, Khan A, Livingston M, Jude EB, Lunt M, Dunn G, Heald AH. Social deprivation modifies the association between incident foot ulceration and mortality in type 1 and type 2 diabetes: a longitudinal study of a primary-care cohort. *Diabetologia* 2018;61:959-967
27. Abbott CA, Carrington AL, Ashe H, Bath S, Every LC, Griffiths J, Hann AW, Hussein A, Jackson N, Johnson KE, Ryder CH, Torkington R, Van Ross ER, Whalley AM, Widdows P, Williamson S, Boulton AJ. The North-West Diabetes Foot Care Study: incidence of, and risk factors for, new diabetic foot ulceration in a community-based patient cohort. *Diabetic medicine : a journal of the British Diabetic Association* 2002;19:377-384
28. Hurst JE, Barn R, Gibson L, Innes H, Bus SA, Kennon B, Wylie D, Woodburn J. Geospatial mapping and data linkage uncovers variability in outcomes of foot disease according to multiple deprivation: a population cohort study of people with diabetes. *Diabetologia* 2020;63:659-667
29. Leese GP, Feng Z, Leese RM, Dibben C, Emslie-Smith A. Impact of health-care accessibility and social deprivation on diabetes related foot disease. *Diabetic medicine : a journal of the British Diabetic Association* 2013;30:484-490
30. Tahrani AA, Altaf QA, Piya MK, Barnett AH. Peripheral and Autonomic Neuropathy in South Asians and White Caucasians with Type 2 Diabetes Mellitus: Possible Explanations for Epidemiological Differences. *Journal of diabetes research* 2017;2017:1273789
31. Chaturvedi N, Abbott CA, Whalley A, Widdows P, Leggetter SY, Boulton AJ. Risk of diabetes-related amputation in South Asians vs. Europeans in the UK. *Diabetic medicine : a journal of the British Diabetic Association* 2002;19:99-104
32. Abbott CA, Garrow AP, Carrington AL, Morris J, Van Ross ER, Boulton AJ. Foot ulcer risk is lower in South-Asian and african-Caribbean compared with European diabetic patients in the U.K.: the North-West diabetes foot care study. *Diabetes care* 2005;28:1869-1875

33. Lacle A, Valero-Juan LF. Diabetes-related lower-extremity amputation incidence and risk factors: a prospective seven-year study in Costa Rica. *Revista panamericana de salud publica* = *Pan American journal of public health* 2012;32:192-198
34. Peters EJ, Lavery LA, Armstrong DG. Diabetic lower extremity infection: influence of physical, psychological, and social factors. *Journal of diabetes and its complications* 2005;19:107-112
35. Bihan H, Ramentol M, Fysekidis M, Auclair C, Gerbaud L, Desbiez F, Peyrol F, Thieblot P, Cohen R, Tauveron I. Screening for deprivation using the EPICES score: a tool for detecting patients at high risk of diabetic complications and poor quality of life. *Diabetes & metabolism* 2012;38:82-85
36. Foster HME, Celis-Morales CA, Nicholl BI, Petermann-Rocha F, Pell JP, Gill JMR, O'Donnell CA, Mair FS. The effect of socioeconomic deprivation on the association between an extended measurement of unhealthy lifestyle factors and health outcomes: a prospective analysis of the UK Biobank cohort. *The Lancet Public health* 2018;3:e576-e585
37. Leese GP, Cochrane L, Mackie AD, Stang D, Brown K, Green V. Measuring the accuracy of different ways to identify the 'at-risk' foot in routine clinical practice. *Diabetic medicine : a journal of the British Diabetic Association* 2011;28:747-754
38. Ruigómez A, Martín-Merino E, Rodríguez LA. Validation of ischemic cerebrovascular diagnoses in the health improvement network (THIN). *Pharmacoepidemiology and drug safety* 2010;19:579-585
39. Martín-Merino E, Fortuny J, Rivero E, García-Rodríguez LA. Validation of diabetic retinopathy and maculopathy diagnoses recorded in a U.K. primary care database. *Diabetes care* 2012;35:762-767
40. Sosenko JM. The prevalence of diabetic neuropathy according to ethnicity. *Current diabetes reports* 2009;9:435-439

characteristics of the study population:

Table 1: Baseline characteristics in the total population and according to [Townsend](#) deprivation quintiles.

Townsend Quintile	1 st Quintile	2 nd Quintile	3 rd Quintile	4 th Quintile	5 th Quintile	Missing	All
Participants, n (%)	32,305 (18.0)	31,247 (17.4)	32,689 (18.2)	30,644 (17.0)	23,380 (13.0)	29,605 (16.5)	179,870
Age, mean(SD)	64.48 (12.33)	64.55 (12.69)	62.96 (13.17)	62.06 (13.68)	60.55 (13.69)	61.76 (13.38)	62.84 (13.21)
Age category, n(%)							
<30 years	129 (0.4)	171 (0.55)	226 (0.69)	305 (1)	277 (1.18)	235 (0.79)	1343 (0.75)
30-40 years	670 (2.07)	776 (2.48)	1176 (3.6)	1,438 (4.69)	1,325 (5.67)	1337 (4.52)	6,722 (3.74)
40-50 years	3,313 (10.26)	3,262 (10.44)	4,232 (12.95)	4,435 (14.47)	3,793 (16.22)	4,249 (14.35)	23,284 (12.94)
50-60 years	7,353 (22.76)	6,804 (21.77)	7,649 (23.4)	7,150 (23.33)	5,937 (25.39)	7,453 (25.17)	42,346 (23.54)
60-70 years	9,749 (30.18)	9,132 (29.23)	9,159 (28.02)	8,097 (26.42)	5,965 (25.51)	7,890 (26.65)	49,992 (27.79)
>70 years	11,091 (34.33)	11,102 (35.53)	10,247 (31.35)	9,219 (30.08)	6,083 (26.02)	8,441 (28.51)	56,183 (31.24)
Male, n (%)	19,107 (59.1)	17,844 (57.1)	18,173 (55.6)	16,446 (53.7)	12,267 (52.5)	16,776 (56.7)	100,613 (55.9)
Ethnicity, n (%)							
Caucasian	13,725 (42.49)	14,207 (45.47)	14,965 (45.78)	14,267 (46.56)	11,720 (50.13)	13,640 (46.07)	82,524 (45.88)
Afro Caribbean	160 (0.5)	171 (0.55)	371 (1.13)	525 (1.71)	715 (3.06)	667 (2.25)	2,609 (1.45)
South Asian	595 (1.84)	596 (1.91)	1,061 (3.25)	1,288 (4.2)	1,061 (4.54)	1,463 (4.94)	6,064 (3.37)
Mixed Race	148 (0.46)	130 (0.42)	202 (0.62)	207 (0.68)	244 (1.04)	380 (1.28)	1,311 (0.73)
Chinese/Middle eastern/Others	48 (0.15)	53 (0.17)	63 (0.19)	92 (0.3)	82 (0.35)	113 (0.38)	451 (0.25)
Missing data	17,629 (54.57)	16,090 (51.49)	16,027 (49.03)	14,265 (46.55)	9,558 (40.88)	13,342 (45.07)	86,911 (48.32)
Smoking Status, n(%)							
Non smoker	17,221 (53.31)	15,710 (50.28)	15,243 (46.63)	13,204 (43.09)	9,343 (39.96)	14,305 (48.32)	85,026 (47.27)
Smoking discontinued	11,843 (36.66)	11,725 (37.52)	12,134 (37.12)	11,252 (36.72)	7,976 (34.11)	10,166 (34.34)	65,096 (36.19)
Smoker	3,185 (9.86)	3,779 (12.09)	5,264 (16.1)	6,156 (20.09)	6,031 (25.8)	5,111 (17.26)	29,526 (16.42)
Missing data	56 (0.17)	33 (0.11)	48 (0.15)	32 (0.1)	30 (0.13)	23 (0.08)	222 (0.12)
BMI, median (IQR)	29.7 (26.5-33.7)	30.2 (26.8-34.4)	30.8 (27.2-35.3)	31.2 (27.5-35.8)	31.6 (27.6-36.5)	30.8 (27.1-35.4)	30.6 (27.1-35.1)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

BMI categories, n(%)	Underweight (<18.5 kg/m ²)	149 (0.46)	170 (0.54)	164 (0.5)	124 (0.4)	133 (0.57)	151 (0.51)	891 (0.5)
	Normal weight (18.5-25 kg/m ²)	4,867 (15.07)	4,206 (13.46)	3,934 (12.03)	3,552 (11.59)	2,693 (11.52)	3,742 (12.64)	22,994 (12.78)
	Overweight (25-30 kg/m ²)	11,666 (36.11)	10,669 (34.14)	10,315 (31.55)	9,054 (29.55)	6,362 (27.21)	9,229 (31.17)	57,295 (31.85)
	Obese (>30 kg/m ²)	15,063 (46.63)	15,643 (50.06)	17,691 (54.12)	17,365 (56.67)	13,772 (58.91)	15,976 (53.96)	95,510 (53.1)
	Missing data	560 (1.73)	559 (1.79)	585 (1.79)	549 (1.79)	420 (1.8)	507 (1.71)	3,180 (1.77)
HbA1c, mean(SD)	HbA1c recorded	28.48 (21.72)	59.01 (22.18)	59.39 (22.27)	59.85 (22.66)	60.41 (23.17)	59.56 (22.46)	59.40 (22.38)
	HbA1c recorded n(%)	30,985 (95.91)	30,035 (96.12)	31,422 (96.12)	29,233 (95.39)	22,373 (95.69)	28,401 (95.93)	17,2449 (95.87)
	HbA1c categories [#] , n(%)							
	<47.5 mmol/mol	11,032 (34.15)	10,395 (33.27)	10,589 (32.39)	9,579 (31.26)	7,320 (31.31)	9,685 (32.71)	58,600 (32.58)
	47.5-58.5 mmol/mol	10,300 (31.88)	10,113 (32.36)	10,486 (32.08)	9,742 (31.79)	7,174 (30.68)	9,295 (31.4)	57,110 (31.75)
	58.5-69.4 mmol/mol	3,062 (9.48)	2,987 (9.56)	3,298 (10.09)	3,178 (10.37)	2,425 (10.37)	2,979 (10.06)	17,929 (9.97)
	>69.4 mmol/mol	6,591 (20.4)	6,540 (20.93)	7,049 (21.56)	6,734 (21.97)	5,454 (23.33)	6,442 (21.76)	38,810 (21.58)
	Missing data	1,320 (4.09)	1,212 (3.88)	1,267 (3.88)	1,411 (4.6)	1,007 (4.31)	1,204 (4.07)	7,421 (4.13)
eGFR, mean(SD)	eGFR recorded, n(%)	78.57 (18.79)	78.67 (19.51)	80.23 (19.94)	80.89 (20.41)	82.82 (20.92)	82.03 (20.12)	80.41 (19.95)
	eGFR categories, n(%)	31,563 (97.70)	30,286 (96.92)	31,863 (97.47)	29,871 (97.48)	22,976 (98.27)	29,181 (98.57)	175,740 (97.70)
	≥60 mL/min/1.73m ²							
	30-59 mL/min/1.73m ²	26,668 (82.55)	25,363 (81.17)	27,083 (82.85)	25,312 (82.6)	19,838 (84.85)	25,291 (85.43)	149,555 (83.15)
	<30 mL/min/1.73m ²	4,659 (14.42)	4,656 (14.9)	4,504 (13.78)	4,303 (14.04)	2,931 (12.54)	3,684 (12.44)	24,737 (13.75)
	Missing data	236 (0.73)	267 (0.85)	276 (0.84)	256 (0.84)	207 (0.89)	206 (0.7)	1,448 (0.81)
		742 (2.3)	961 (3.08)	826 (2.53)	773 (2.52)	404 (1.73)	424 (1.43)	4,130 (2.3)
CVD, n (%)								
Hypertension, n (%)								
Retinopathy, n (%)								
Treatment, n (%)								
Insulin								

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Lipid Drugs	23,621 (73.12)	22,764 (72.85)	23,865 (73.01)	22,322 (72.84)	17,205 (73.59)	20,389 (68.87)	130,166 (72.37)
Other DM Drugs	17,135 (53.04)	16,620 (53.19)	18,630 (56.99)	18,147 (59.22)	14,489 (61.97)	17,620 (59.52)	10,2641 (57.06)
Foot Risk, n (%)							
High	400 (1.24)	493 (1.58)	502 (1.54)	525 (1.71)	471 (2.01)	379 (1.28)	2,770 (1.54)
Moderate	2,407 (7.45)	2,392 (7.66)	2,756 (8.43)	2,660 (8.68)	2,244 (9.6)	2,440 (8.24)	14,899 (8.28)
Low	13,270 (41.08)	13,367 (42.78)	13,948 (42.67)	13,046 (42.57)	9,568 (40.92)	14,913 (50.37)	78,112 (43.43)
Declined	133 (0.41)	131 (0.42)	174 (0.53)	182 (0.59)	212 (0.91)	216 (0.73)	1048 (0.58)
Missing data	16,095 (49.82)	14,864 (47.57)	15,309 (46.83)	14,231 (46.44)	10,885 (46.56)	11,657 (39.38)	83,041 (46.17)
DFD, n (%)^a	4,496 (13.92)	4,616 (14.77)	4,964 (15.19)	4,787 (15.62)	3,895 (16.66)	3,686 (12.45)	26,444 (14.7)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

Formatted: English (U.S.)

<u>Townsend Quintile</u>	<u>1st Quintile</u>	<u>2nd Quintile</u>	<u>3rd Quintile</u>	<u>4th Quintile</u>	<u>5th Quintile</u>	<u>Missing</u>	<u>All</u>
Participants, n (%)	(n=31,732)	(n=30,655)	(n=32,021)	(n=29,984)	(n=22,881)	(n=29,086)	(n=176,359)
Age, mean(SD)	64.52 (12.26)	64.59 (12.62)	63.02 (13.12)	62.15 (13.60)	60.64 (13.58)	61.83 (13.30)	62.91 (13.13)
Age category, n(%)							
<30 years	105 (0.33)	145 (0.47)	195 (0.61)	262 (0.87)	232 (1.01)	199 (0.68)	1,138 (0.65)
30-40 years	646 (2.04)	747 (2.44)	1,136 (3.55)	1,380 (4.60)	1,277 (5.58)	1,290 (4.44)	6,476 (3.67)
40-50 years	3,242 (10.22)	3,197 (10.43)	4,143 (12.94)	4,336 (14.46)	3,712 (16.22)	4,174 (14.35)	22,804 (12.93)

<u>50-60 years</u>	<u>7,241 (22.82)</u>	<u>6,670 (21.76)</u>	<u>7,494 (23.40)</u>	<u>7,002 (23.35)</u>	<u>5,829 (25.48)</u>	<u>7,337 (25.23)</u>	<u>41,573 (23.57)</u>
<u>60-70 years</u>	<u>9,611 (30.29)</u>	<u>8,988 (29.32)</u>	<u>8,993 (28.08)</u>	<u>7,950 (26.51)</u>	<u>5,863 (25.62)</u>	<u>7,770 (26.71)</u>	<u>49,175 (27.88)</u>
<u>>70 years</u>	<u>10,887 (34.31)</u>	<u>10,908 (35.58)</u>	<u>10,060 (31.42)</u>	<u>9,054 (30.20)</u>	<u>5,968 (26.08)</u>	<u>8,316 (28.59)</u>	<u>55,193 (31.30)</u>
<u>Male, n (%)</u>	<u>18,779 (59.18)</u>	<u>17,518 (57.15)</u>	<u>17828 (55.68)</u>	<u>16,114 (53.74)</u>	<u>12,041 (52.62)</u>	<u>16,497 (56.72)</u>	<u>98,777 (56.01)</u>
<u>Ethnicity, n (%)</u>							
<u>Caucasian</u>	<u>13,452 (42.39)</u>	<u>13,911 (45.38)</u>	<u>14,626 (45.68)</u>	<u>13,938 (46.48)</u>	<u>11,467 (50.12)</u>	<u>13,394 (46.05)</u>	<u>80,788 (45.81)</u>
<u>Afro Caribbean</u>	<u>583 (1.84)</u>	<u>573 (1.87)</u>	<u>1,010 (3.15)</u>	<u>1,244 (4.15)</u>	<u>1,038 (4.54)</u>	<u>1,426 (4.90)</u>	<u>5,874 (3.33)</u>
<u>South Asian</u>	<u>159 (0.50)</u>	<u>168 (0.55)</u>	<u>357 (1.11)</u>	<u>499 (1.66)</u>	<u>687 (3.00)</u>	<u>653 (2.25)</u>	<u>2,523 (1.43)</u>
<u>Mixed Race</u>	<u>143 (0.45)</u>	<u>126 (0.41)</u>	<u>196 (0.61)</u>	<u>200 (0.67)</u>	<u>234 (1.02)</u>	<u>372 (1.28)</u>	<u>1,271 (0.72)</u>
<u>Chinese/Middle Eastern/Others</u>	<u>45 (0.14)</u>	<u>51 (0.17)</u>	<u>62 (0.19)</u>	<u>87 (0.29)</u>	<u>78 (0.34)</u>	<u>112 (0.39)</u>	<u>435 (0.25)</u>
<u>Missing data</u>	<u>17,350 (54.68)</u>	<u>15,826 (51.63)</u>	<u>15,770 (49.25)</u>	<u>14,016 (46.74)</u>	<u>9,377 (40.98)</u>	<u>13,129 (45.14)</u>	<u>85,468 (48.46)</u>
<u>Smoking Status, n(%)</u>							
<u>Non-smoker</u>	<u>16,917 (53.31)</u>	<u>15,410 (50.27)</u>	<u>14,909 (46.56)</u>	<u>12,920 (43.09)</u>	<u>9,153 (40.00)</u>	<u>14,052 (48.31)</u>	<u>83,361 (47.27)</u>
<u>Smoking discontinued</u>	<u>11,638 (36.68)</u>	<u>11,503 (37.52)</u>	<u>11,921 (37.23)</u>	<u>11,029 (36.78)</u>	<u>7,810 (34.13)</u>	<u>10,010 (34.42)</u>	<u>63,911 (36.24)</u>
<u>Smoker</u>	<u>3,122 (9.84)</u>	<u>3,710 (12.10)</u>	<u>5,146 (16.07)</u>	<u>6,005 (20.03)</u>	<u>5,888 (25.73)</u>	<u>5,006 (17.21)</u>	<u>28,877 (16.37)</u>
<u>Missing data</u>	<u>55 (0.17)</u>	<u>32 (0.10)</u>	<u>45 (0.14)</u>	<u>30 (0.10)</u>	<u>30 (0.13)</u>	<u>18 (0.06)</u>	<u>210 (0.12)</u>
<u>BMI, median (IQR)</u>	<u>29.00 (26.00-33.00)</u>	<u>30.00 (26.00-34.00)</u>	<u>30.00 (27.00-35.00)</u>	<u>31.00 (27.00-35.00)</u>	<u>31.00 (27.00-36.00)</u>	<u>30.00 (27.00-35.00)</u>	<u>30.00 (27.00-35.00)</u>
<u>BMI categories, n(%)</u>							
<u>Underweight (<18.5 kg/m2)</u>	<u>145 (0.46)</u>	<u>164 (0.53)</u>	<u>159 (0.50)</u>	<u>116 (0.39)</u>	<u>128 (0.56)</u>	<u>142 (0.49)</u>	<u>854 (0.48)</u>
<u>Normal weight (18.5-25 kg/m2)</u>	<u>4,762 (15.01)</u>	<u>4,106 (13.39)</u>	<u>3,844 (12.00)</u>	<u>3,455 (11.52)</u>	<u>2,629 (11.49)</u>	<u>3,656 (12.57)</u>	<u>22,452 (12.73)</u>
<u>Overweight (25-30 kg/m2)</u>	<u>11,482 (36.18)</u>	<u>10,479 (34.18)</u>	<u>10,137 (31.66)</u>	<u>8,890 (29.65)</u>	<u>6,233 (27.24)</u>	<u>9,079 (31.21)</u>	<u>56,300 (31.92)</u>
<u>Obese (>30 kg/m2)</u>	<u>14,810 (46.67)</u>	<u>15,374 (50.15)</u>	<u>17,320 (54.09)</u>	<u>17,000 (56.70)</u>	<u>13,485 (58.94)</u>	<u>15,720 (54.05)</u>	<u>93,709 (53.14)</u>
<u>Missing data</u>	<u>533 (1.68)</u>	<u>532 (1.74)</u>	<u>561 (1.75)</u>	<u>523 (1.74)</u>	<u>406 (1.77)</u>	<u>489 (1.68)</u>	<u>3,044 (1.73)</u>
<u>HbA1c, mean(SD)</u>	<u>58.54 (21.73)</u>	<u>59.04 (22.17)</u>	<u>59.40 (22.28)</u>	<u>59.87 (22.61)</u>	<u>60.45 (23.16)</u>	<u>59.57 (22.44)</u>	<u>59.43 (22.37)</u>
<u>HbA1c recorded n(%)</u>	<u>30,459 (95.99)</u>	<u>29,502 (96.24)</u>	<u>30,800 (96.19)</u>	<u>28,621 (95.45)</u>	<u>21,913 (95.77)</u>	<u>27,930 (96.03)</u>	<u>169,225 (95.95)</u>
<u>HbA1c categories#, n(%)</u>							

<u>≤47.5 mmol/mol</u>	<u>10,781 (33.98)</u>	<u>10,191 (33.24)</u>	<u>10,365 (32.37)</u>	<u>9,352 (31.19)</u>	<u>7,138 (31.20)</u>	<u>9,498 (32.65)</u>	<u>57,325 (32.50)</u>
<u>47.5-58.5 mmol/mol</u>	<u>10,168 (32.04)</u>	<u>9,937 (32.42)</u>	<u>10,294 (32.15)</u>	<u>9,538 (31.81)</u>	<u>7,038 (30.76)</u>	<u>9,166 (31.51)</u>	<u>56,141 (31.83)</u>
<u>58.5-69.4 mmol/mol</u>	<u>3,014 (9.50)</u>	<u>2,943 (9.60)</u>	<u>3,232 (10.09)</u>	<u>3,131 (10.44)</u>	<u>2,383 (10.41)</u>	<u>2,936 (10.09)</u>	<u>17,639 (10.00)</u>
<u>>69.4 mmol/mol</u>	<u>6,496 (20.47)</u>	<u>6,431 (20.98)</u>	<u>6,909 (21.58)</u>	<u>6,600 (22.01)</u>	<u>5,354 (23.40)</u>	<u>6,330 (21.76)</u>	<u>38,120 (21.62)</u>
<u>Missing data</u>	<u>1,273 (4.01)</u>	<u>1,153 (3.76)</u>	<u>1,221 (3.81)</u>	<u>1,363 (4.55)</u>	<u>968 (4.23)</u>	<u>1,156 (3.97)</u>	<u>7,134 (4.05)</u>
<u>eGFR, mean(SD)</u>	<u>78.55 (18.74)</u>	<u>78.62 (19.46)</u>	<u>80.17 (19.90)</u>	<u>80.78 (20.36)</u>	<u>82.71 (20.83)</u>	<u>81.94 (19.98)</u>	<u>80.34 (19.90)</u>
<u>eGFR recorded, n(%)</u>	<u>31,001 (97.70)</u>	<u>29,704 (96.90)</u>	<u>31,210 (97.47)</u>	<u>29,230 (97.49)</u>	<u>22,486 (98.27)</u>	<u>28,674 (98.58)</u>	<u>172,305 (97.70)</u>
<u>eGFR categories, n(%)</u>							
<u>≥60 mL/min/1.73m2</u>	<u>26,200 (82.57)</u>	<u>24,866 (81.12)</u>	<u>26,515 (82.81)</u>	<u>24,748 (82.54)</u>	<u>19,410 (84.83)</u>	<u>24,835 (85.38)</u>	<u>146,574 (83.11)</u>
<u>30-59 mL/min/1.73m2</u>	<u>4,571 (14.41)</u>	<u>4,575 (14.92)</u>	<u>4,424 (13.82)</u>	<u>4,230 (14.11)</u>	<u>2,876 (12.57)</u>	<u>3,636 (12.50)</u>	<u>24,312 (13.79)</u>
<u><30 mL/min/1.73m2</u>	<u>230 (0.72)</u>	<u>263 (0.86)</u>	<u>271 (0.85)</u>	<u>252 (0.84)</u>	<u>200 (0.87)</u>	<u>203 (0.70)</u>	<u>1,419 (0.80)</u>
<u>Missing data</u>	<u>731 (2.30)</u>	<u>951 (3.10)</u>	<u>811 (2.53)</u>	<u>754 (2.51)</u>	<u>395 (1.73)</u>	<u>412 (1.42)</u>	<u>4,054 (2.30)</u>
<u>CVD, n (%)</u>	<u>7,052 (22.22)</u>	<u>7,222 (23.56)</u>	<u>7,522 (23.49)</u>	<u>7,331 (24.45)</u>	<u>5,702 (24.92)</u>	<u>6,255 (21.51)</u>	<u>41,084 (23.30)</u>
<u>Hypertension, n (%)</u>	<u>17,731 (55.88)</u>	<u>17,250 (56.27)</u>	<u>17,675 (55.20)</u>	<u>16,148 (53.86)</u>	<u>11,988 (52.39)</u>	<u>15,495 (53.27)</u>	<u>96,287 (54.60)</u>
<u>Retinopathy, n (%)</u>	<u>905 (2.85)</u>	<u>949 (3.10)</u>	<u>1,038 (3.24)</u>	<u>995 (3.32)</u>	<u>773 (3.38)</u>	<u>942 (3.24)</u>	<u>5,602 (3.18)</u>
<u>Treatment, n (%)</u>							
<u>Insulin</u>	<u>629 (1.98)</u>	<u>641 (2.09)</u>	<u>768 (2.40)</u>	<u>752 (2.51)</u>	<u>665 (2.91)</u>	<u>738 (2.54)</u>	<u>4,193 (2.38)</u>
<u>Lipid Drugs</u>	<u>23,254 (73.28)</u>	<u>22,415 (73.12)</u>	<u>23,450 (73.23)</u>	<u>21,918 (73.10)</u>	<u>16,926 (73.97)</u>	<u>20,084 (69.05)</u>	<u>128,047 (72.61)</u>
<u>Other DM Drugs</u>	<u>16,826 (53.03)</u>	<u>16,280 (53.11)</u>	<u>18,244 (56.98)</u>	<u>17,761 (59.23)</u>	<u>14,209 (62.10)</u>	<u>17,294 (59.46)</u>	<u>100,614 (57.05)</u>
<u>Foot Risk, n (%)</u>							
<u>High</u>	<u>391 (1.23)</u>	<u>485 (1.58)</u>	<u>495 (1.55)</u>	<u>513 (1.71)</u>	<u>454 (1.98)</u>	<u>369 (1.27)</u>	<u>2,707 (1.53)</u>
<u>Moderate</u>	<u>2,346 (7.39)</u>	<u>2,344 (7.65)</u>	<u>2,696 (8.42)</u>	<u>2,599 (8.67)</u>	<u>2,193 (9.58)</u>	<u>2,394 (8.23)</u>	<u>14,572 (8.26)</u>
<u>Low</u>	<u>12,985 (40.92)</u>	<u>13,044 (42.55)</u>	<u>13,568 (42.37)</u>	<u>12,699 (42.35)</u>	<u>9,322 (40.74)</u>	<u>14,605 (50.21)</u>	<u>76,223 (43.22)</u>
<u>Declined</u>	<u>126 (0.40)</u>	<u>128 (0.42)</u>	<u>171 (0.53)</u>	<u>176 (0.59)</u>	<u>208 (0.91)</u>	<u>213 (0.73)</u>	<u>1,022 (0.58)</u>
<u>Missing data</u>	<u>15,884 (50.06)</u>	<u>14,654 (47.80)</u>	<u>15,091 (47.13)</u>	<u>13,997 (46.68)</u>	<u>10,704 (46.78)</u>	<u>11,505 (39.56)</u>	<u>81,835 (46.40)</u>
<u>DFD, n (%) *</u>	<u>4,437 (13.98)</u>	<u>4,554 (14.86)</u>	<u>4,910 (15.33)</u>	<u>4,720 (15.74)</u>	<u>3,830 (16.74)</u>	<u>3,643 (12.52)</u>	<u>26,094 (14.80)</u>

N: Number of patients, **SD**: Standard Deviation, **BMI**: Body Mass Index, **HbA1c**: Haemoglobin A1c, **eGFR**: estimated Glomerular Filtration Rate, **CVD**: Cardiovascular Disease, **DFD**: Diabetic Foot Disease

[#] ≤47.5 mmol/mol = ≤6.5%, 47.5-58.5 mmol/mol = 6.5-7.5%, 58.5-69.4 mmol/mol = 7.5-8.5%, >69.4 mmol/mol = >8.5%

*DFD refers to baseline, these patients are excluded from our study

Table 2. ~~The relationship between~~ Townsend ~~deprivation~~ quintiles and ~~the incidence~~ of diabetic foot disease ~~as a composite outcome~~.

(Townsend quantile)	Composite DFD* n (%)	Median Follow up [years(IQR)]	Incidence rate per 1,000 person years(95% CI)	aHR (95% CI)*
1	3,429 (12.33)	3.28 (1.38-5.96)	31.03 (30.01-32.08)	Ref
2	3,385 (12.71)	3.23 (1.38-5.89)	32.33 (31.26-33.44)	1.03 (0.99-1.08)
3	3,440 (12.41)	3.19 (1.38-5.86)	31.69 (30.64-32.76)	1.04 (0.99-1.09)
4	3,293 (12.74)	3.11 (1.35-5.74)	32.98 (31.87-34.12)	1.09 (1.04-1.15)
5	2,662 (13.66)	3.08 (1.30-5.63)	35.98 (34.64-37.38)	1.21 (1.15-1.27)
Missing data	2,828 (10.91)	3.33 (1.41-6.13)	26.54 (25.58-27.53)	0.95 (0.90-0.99)

(Townsend quantile)	Composite DFD*n (%)	Median Follow up [years (IQR)]	Incidence rate per 1,000 person years (95% CI)	aHR (95% CI)*
1	3,267 (11.97)	3.33 (1.42-6.03)	29.77 (28.77-30.81)	Ref
2	3,238 (12.41)	3.29 (1.42-5.96)	31.17 (30.11-32.26)	1.04 (0.99-1.09) p=0.110
3	3,278 (12.09)	3.25 (1.43-5.95)	30.45 (29.42-31.51)	1.04 (0.99-1.09) p=0.092
4	3,133 (12.40)	3.17 (1.38-5.81)	31.69 (30.60-32.82)	1.10 (1.04-1.15) p<0.001
5	2,557 (13.42)	3.15 (1.34-5.72)	34.86 (33.54-36.24)	1.22 (1.16-1.29) p<0.001
Missing data	2,680 (10.53)	3.38 (1.45-6.21)	25.32 (24.38-26.30)	0.94 (0.90-0.99) p=0.028

N: number of patients, **IQR**: Interquartile Range, **DFD**: Diabetic Foot Disease, **aHR**: adjusted Hazard Ratio.

*The adjustment model includes sex, age at type 2 diabetes diagnosis, ethnicity, smoking, BMI, HbA1c, cardiovascular disease, retinopathy, renal function analysed as eGFR, insulin treatment, glucose-lowering medications and baseline foot risk.

#In case of multiple DFD events at follow-up, censoring at the first event.

Table 3. The relationship between Townsend deprivation quintiles and the incidence of peripheral neuropathy, foot ulcer, peripheral vascular disease, lower limb amputation, Charcot arthropathy and gangrene, the different types of diabetic foot neuropathy.

Outcome	n (%)	Median Follow up [years(IQR)]	Incidence rate per 1,000-person years(95%-CI)	aHR (95%-CI)*
Peripheral neuropathy	-	-	-	-
1	2,475 (8.9)	3.43 (1.48-6.15)	21.67 (20.83-22.54)	Ref
2	2,459 (9.23)	3.38 (1.48-6.11)	22.71 (21.83-23.63)	1.05 (0.99-1.11)
3	2,401 (8.66)	3.35 (1.48-6.08)	21.32 (20.48-22.19)	1.01 (0.96-1.07)
4	2,334 (9.03)	3.27 (1.43-5.96)	22.55 (21.65-23.49)	1.09 (1.03-1.16)
5	1,828 (9.38)	3.26 (1.39-5.94)	23.63 (22.57-24.74)	1.17 (1.10-1.24)
Missing data	1,962 (7.57)	3.47 (1.51-6.34)	17.84 (17.07-18.65)	0.93 (0.87-0.98)
Ulcer	-	-	-	-
1	410 (1.47)	3.85 (1.73-6.59)	3.33 (3.02-3.67)	Ref
2	410 (1.54)	3.80 (1.74-6.56)	3.51 (3.18-3.87)	1.03 (0.90-1.18)
3	430 (1.55)	3.72 (1.70-6.55)	3.55 (3.23-3.91)	1.06 (0.93-1.22)
4	409 (1.58)	3.65 (1.66-6.45)	3.66 (3.32-4.03)	1.10 (0.96-1.26)
5	353 (1.81)	3.65 (1.64-6.38)	4.22 (3.8-4.68)	1.28 (1.11-1.48)
Missing data	405 (1.56)	3.87 (1.70-6.86)	3.43 (3.12-3.79)	1.04 (0.91-1.20)
Peripheral vascular disease	-	-	-	-
1	1,052 (3.78)	3.68 (1.63-6.42)	8.78 (8.27-9.33)	Ref
2	1,075 (4.04)	3.65 (1.63-6.41)	9.46 (8.91-10.05)	1.06 (0.97-1.15)
3	1,148 (4.14)	3.56 (1.61-6.36)	9.78 (9.23-10.36)	1.11 (1.02-1.20)
4	1,102 (4.26)	3.48 (1.57-6.26)	10.17 (9.59-10.79)	1.14 (1.05-1.25)
5	998 (5.12)	3.46 (1.55-6.18)	12.39 (11.64-13.18)	1.39 (1.27-1.52)
Missing data	850 (3.28)	3.73 (1.64-6.69)	7.36 (6.88-7.87)	0.92 (0.84-1.01)
Lower limb amputation	-	-	-	-
1	32 (0.12)	3.90 (1.76-6.64)	0.26 (0.18-0.36)	Ref

2	31 (0.12)	3.85 (1.76-6.62)	0.26 (0.18-0.37)	1.01 (0.62-1.66)
3	48 (0.17)	3.77 (1.73-6.61)	0.39 (0.3-0.52)	1.58 (1.01-2.47)
4	45 (0.17)	3.71 (1.69-6.52)	0.4 (0.3-0.53)	1.61 (1.02-2.55)
5	37 (0.19)	3.71 (1.67-6.46)	0.44 (0.32-0.6)	1.75 (1.08-2.84)
Missing data	34 (0.13)	3.91 (1.72-6.94)	0.29 (0.2-0.4)	1.11 (0.68-1.81)
Charecot arthropathy				
	-	-	-	-
1	12 (0.04)	3.90 (1.76-6.64)	0.1 (0.05-0.17)	Ref
2	8 (0.03)	3.85 (1.76-6.62)	0.07 (0.03-0.14)	0.72 (0.29-1.76)
3	8 (0.03)	3.77 (1.74-6.61)	0.07 (0.03-0.13)	0.67 (0.27-1.64)
4	12 (0.05)	3.71 (1.69-6.53)	0.11 (0.06-0.19)	1.08 (0.48-2.42)
5	16 (0.08)	3.71 (1.67-6.46)	0.19 (0.12-0.31)	1.78 (0.83-3.86)
Missing data	6 (0.02)	3.92 (1.72-6.95)	0.05 (0.02-0.11)	0.47 (0.17-1.25)
Gangrene				
	-	-	-	-
1	1 (0)	3.91 (1.76-6.64)	0.01 (0-0.06)	Ref
2	3 (0.01)	3.85 (1.76-6.62)	0.03 (0.01-0.08)	3.23 (0.33-31.62)
3	2 (0.01)	3.77 (1.73-6.61)	0.02 (0-0.07)	2.26 (0.20-25.66)
4	4 (0.02)	3.71 (1.69-6.53)	0.04 (0.01-0.09)	1.77 (0.51-44.58)
5	4 (0.02)	3.71 (1.67-6.47)	0.05 (0.02-0.13)	5.62 (0.60-52.87)
Missing data	1 (0)	3.92 (1.72-6.95)	-0.01 (0-0.06)	1.11 (0.07-18.13)

Outcome	n (%)	<u>Median Follow up</u> [years(IQR)]	<u>Incidence rate per 1,000 person</u> <u>years(95% CI)</u>	<u>aHR (95% CI)*</u>
<u>Peripheral neuropathy</u>				
1	2,483 (9.10)	3.47 (1.51-6.18)	21.98 (21.13-22.86)	Ref
2	2,449 (9.38)	3.43 (1.51-6.15)	22.88 (21.99-23.81)	1.04 (0.98-1.10) p=0.169
3	2,394 (8.83)	3.39 (1.52-6.15)	21.53 (20.68-22.41)	1.01 (0.96-1.07) p=0.716
4	2,320 (9.18)	3.32 (1.47-6.02)	22.72 (21.82-23.67)	1.08 (1.02-1.15) p=0.006
5	1,836 (9.64)	3.31 (1.43-5.99)	24.05 (22.98-25.18)	1.18 (1.11-1.25) p<0.001
Missing data	1,963 (7.72)	3.52 (1.54-6.38)	18.05 (17.27-18.87)	0.92 (0.87-0.98) p=0.009
<u>Ulcer</u>				
1	192 (0.70)	3.94 (1.79-6.67)	1.57 (1.36-1.80)	Ref
2	210 (0.80)	3.90 (1.80-6.64)	1.81 (1.58-2.07)	1.13 (0.93-1.38) p=0.221

<u>3</u>	<u>209 (0.77)</u>	<u>3.82 (1.76-6.65)</u>	<u>1.74 (1.52-1.99)</u>	<u>1.11 (0.91-1.35) p=0.288</u>
<u>4</u>	<u>220 (0.87)</u>	<u>3.73 (1.71-6.55)</u>	<u>1.98 (1.74-2.26)</u>	<u>1.28 (1.05-1.55) p=0.014</u>
<u>5</u>	<u>186 (0.98)</u>	<u>3.75 (1.70-6.49)</u>	<u>2.23 (1.93-2.58)</u>	<u>1.44 (1.17-1.77) p<0.001</u>
Missing data	<u>222 (0.87)</u>	<u>3.95 (1.74-6.96)</u>	<u>1.89 (1.66-2.16)</u>	<u>1.18 (0.97-1.43) p=0.103</u>
Peripheral vascular disease				
<u>1</u>	<u>1,045 (3.83)</u>	<u>3.75 (1.67-6.47)</u>	<u>8.81 (8.29-9.36)</u>	<u>Ref</u>
<u>2</u>	<u>1,067 (4.09)</u>	<u>3.71 (1.66-6.45)</u>	<u>9.49 (8.94-10.08)</u>	<u>1.06 (0.97-1.15) p=0.201</u>
<u>3</u>	<u>1,141 (4.21)</u>	<u>3.61 (1.65-6.41)</u>	<u>9.84 (9.28-10.42)</u>	<u>1.11 (1.02-1.21) p=0.015</u>
<u>4</u>	<u>1,093 (4.33)</u>	<u>3.55 (1.60-6.31)</u>	<u>10.22 (9.63-10.84)</u>	<u>1.15 (1.05-1.25) p=0.002</u>
<u>5</u>	<u>994 (5.22)</u>	<u>3.53 (1.58-6.23)</u>	<u>12.49 (11.74-13.29)</u>	<u>1.40 (1.28-1.53) p<0.001</u>
Missing data	<u>845 (3.32)</u>	<u>3.79 (1.67-6.76)</u>	<u>7.39 (6.91-7.91)</u>	<u>0.92 (0.84-1.01) p=0.083</u>
Lower limb amputation				
<u>1</u>	<u>32 (0.12)</u>	<u>3.95 (1.80-6.69)</u>	<u>0.26 (0.18-0.37)</u>	<u>Ref</u>
<u>2</u>	<u>31 (0.12)</u>	<u>3.92 (1.80-6.67)</u>	<u>0.27 (0.19-0.38)</u>	<u>1.02 (0.62-1.67) p=0.952</u>
<u>3</u>	<u>47 (0.17)</u>	<u>3.84 (1.77-6.67)</u>	<u>0.39 (0.29-0.52)</u>	<u>1.54 (0.98-2.42) p=0.060</u>
<u>4</u>	<u>44 (0.17)</u>	<u>3.76 (1.72-6.58)</u>	<u>0.40 (0.29-0.53)</u>	<u>1.58 (1.00-2.50) p=0.052</u>
<u>5</u>	<u>37 (0.19)</u>	<u>3.78 (1.71-6.53)</u>	<u>0.44 (0.32-0.61)</u>	<u>1.75 (1.08-2.83) p=0.023</u>
Missing data	<u>34 (0.13)</u>	<u>3.97 (1.76-7.00)</u>	<u>0.29 (0.21-0.40)</u>	<u>1.12 (0.69-1.82) p=0.658</u>
Charcot arthropathy				
<u>1</u>	<u>13 (0.05)</u>	<u>3.96 (1.80-6.70)</u>	<u>0.11 (0.06-0.18)</u>	<u>Ref</u>
<u>2</u>	<u>11 (0.04)</u>	<u>3.92 (1.80-6.67)</u>	<u>0.09 (0.05-0.17)</u>	<u>0.90 (0.40-2.02) p=0.807</u>
<u>3</u>	<u>11 (0.04)</u>	<u>3.85 (1.78-6.67)</u>	<u>0.09 (0.05-0.16)</u>	<u>0.84 (0.38-1.89) p=0.679</u>
<u>4</u>	<u>12 (0.05)</u>	<u>3.76 (1.72-6.59)</u>	<u>0.11 (0.06-0.19)</u>	<u>0.99 (0.45-2.19) p=0.983</u>
<u>5</u>	<u>16 (0.08)</u>	<u>3.78 (1.72-6.54)</u>	<u>0.19 (0.12-0.31)</u>	<u>1.65 (0.78-3.49) p=0.191</u>
Missing data	<u>6 (0.02)</u>	<u>3.97 (1.76-7.01)</u>	<u>0.05 (0.02-0.11)</u>	<u>0.43 (0.16-1.14) p=0.090</u>
Gangrene				
<u>1</u>	<u>1 (0.00)</u>	<u>3.96 (1.80-6.70)</u>	<u>0.01 (0.00-0.06)</u>	<u>Ref</u>
<u>2</u>	<u>5 (0.02)</u>	<u>3.92 (1.80-6.67)</u>	<u>0.04 (0.02-0.10)</u>	<u>5.01 (0.58-42.94) p=0.142</u>
<u>3</u>	<u>4 (0.01)</u>	<u>3.85 (1.78-6.67)</u>	<u>0.03 (0.01-0.09)</u>	<u>3.99 (0.44-35.85) p=0.216</u>
<u>4</u>	<u>9 (0.04)</u>	<u>3.76 (1.72-6.59)</u>	<u>0.08 (0.04-0.16)</u>	<u>9.82 (1.23-78.17) p=0.031</u>
<u>5</u>	<u>6 (0.03)</u>	<u>3.78 (1.72-6.54)</u>	<u>0.07 (0.03-0.16)</u>	<u>8.49 (1.01-71.58) p=0.049</u>
Missing data	<u>5 (0.02)</u>	<u>3.97 (1.76-7.01)</u>	<u>0.04 (0.02-0.10)</u>	<u>5.35 (0.62-46.07) p=0.127</u>

HR: Hazard Ratio, **95% CI:** Confidence Interval, **aHR:** adjusted Hazard Ratio

*The results are adjusted for: age at type 2 diabetes diagnosis, sex, ethnicity, smoking status, BMI, eGFR, retinopathy, hypertension, cardiovascular disease, HbA1c, insulin treatment, glucose lowering medication, lipid lowering medication

Figure legends.

Figure 1. ~~The incidence of individual components of diabetic foot disease outcomes in the different quantiles of Townsend score.~~Social Townsend deprivation quintiles and the incident risk of individual components of diabetic foot disease