



# Newsletter

Fall 2003

President: Marlene Reid, DPM  
Editor: Karen Glandon, DPM

*Serving Women Podiatrists Nationwide*

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## AAWP President's Report

# The AAWP Wants to See More Women on Committees!

by Marlene Reid, DPM  
President AAWP

Attention all members interested in serving on an APMA Committee! It is time for you to submit your written request to the APMA—don't wait until the last minute! The President-Elect is responsible for choosing committee members.

Requests for committee assignments should include not only the specific committee you are interested in, but general areas of interest and expertise. Please send a cover letter indicating preferences and a current CV.

A call for member involvement is made for, but is not limited to, the following committees. Check the APMA website for a full list of APMA committees and their descriptions.

- Appeals and Control Committee
- Arthritis Advisory Committee
- Awards and Recognition Committee
- Clinical Advisory Task Force
- Coding Committee
- Development Committee
- Diabetes Advisory Committee
- Education Committee
- Health Policy Committee
- Health Systems Committee
- Internet and Computer Technology Committee
- Legislative Committee
- Membership and Student Liaison Committee

- Physicians' Recovery Network
- Podiatric Research Advisory Committee
- Podiatric Seals Committee
- Public Education and Information Committee
- Public Health and Preventive Podiatric Medicine Committee
- Student Recruitment Committee
- Young Members' Committee

All requests will be carefully considered and should be sent to

### **BOTH:**

Stephanie Christiansen, Governance Administrator  
APMA  
9312 Old Georgetown Rd.  
Bethesda, MD 20814

### **AND**

Lloyd S. Smith, DPM  
APMA President-Elect  
10 Langley Rd.  
Newton, MA 02459

Questions should be directed to Ms. Christiansen at (800) ASK-APMA. The deadline for nominations is November 1, 2003. ❖

## AAWP Members Volunteer for the APMA USA Today Hotline

Dr. Marlene Reid, President, and Dr. Colleen Schwartz, Executive Director, were among the many women who participated in this year's *USA Today* Hotline which allowed readers across the entire country to call in and speak to a podiatrist regarding a foot or ankle problem. Other AAWP members who participated in the program were Dr. Rita Rae Fontenot, Dr. Patricia Schultz and Dr. Kathleen Stone, member, APMA Board of Trustees. Of the 80 participants, 14 were women!

Approximately 2000 phone calls are received annually from all parts of the country, both rural and urban areas, with representative foot problems of every age group. "Some questions were very basic," said Reid, "but some questions were very technical and seemed to be as if the callers were seeking second opinions."

This year's Hotline was held at the USA Today Headquarters in Tysons Corner, VA during the APMA National Leadership Conference. This was the 11th year that the APMA provided volunteers for the phone-in program. ❖



Marlene Reid, DPM



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Communications regarding the newsletter should be addressed to Editor Karen Glandon, DPM.

For questions regarding advertising in the newsletter, please contact the Executive Director. Camera-ready ads are preferred.

The AAWP Newsletter is the official newsletter of the AAWP, Inc. The contents contained herein are not necessarily reflections of any policy or opinion of the AAWP, Inc. All articles represent the individual contributors who are at liberty to express their own views. We are willing to publish opposing viewpoints.

### PRESS SCHEDULE FOR NEWSLETTER

The AAWP Newsletter is published three times each calendar year. The deadlines for the newsletter are January 1, May 1 and September 1. Articles from the membership for publication are appreciated and encouraged.

Don't forget to use the AAWP Newsletter to announce special events/promotions, discuss topical issues, acknowledge members and student chapter activities/achievements, that promote women in the podiatric medical community.

# Mission to Jamaica

by Nicklya Harris, BUSGMS

From May 16 through May 25, 2003, seventeen health professionals including five physicians, a nutritionist, an office manager, and ten podiatric medical students, traveled from South Florida to Jamaica to conduct a medical mission to one of the most impoverished areas of the continent. Four members of BUSGMS AAWP 2003 were able to attend: Nicklya Harris (senior), Melissa Marshall, Elizabeth Londono, and Tiomara Paylor (all sophomores).

The trip was coordinated by the Barry University chapter of the Student National Podiatric Medical Association (SNPMA). While in Jamaica for nine days, the group provided humanitarian healthcare and medications to the underserved populations in makeshift clinics in the towns of Linstead, Ewarton, Treachway, Lluisdasvale, Boscobel, Highgate, and Kingston. All of the students and physicians sacrificed their time and paid their own expenses in order to make this mission trip a reality. The patients ranged in age from newborns to geriatric. Ailments such as diabetes, hypertension, severe malnutrition, poor hygiene, extreme poverty, respiratory, gastrointestinal disorders and sexually transmitted diseases were just some of the major health care issues addressed. Over 1100 people were seen.

Among the professions represented were specialties in the field of family medicine, pediatrics, podiatric medicine, and nutrition. Dr. Clifford G. O'Connor, Medical Team Leader and Advisor to the SNPMA organization as well as Clinical Professor from Barry expressed "...this is a first for our organization...and the learning opportunity that was experienced by the medical students and professionals will not only transform the lives of the participants but also the recipients of the medical care that was rendered."

To show their appreciation for the mission, the Minister of Transport and Work, the host physician and members of the Jamaican Parliament hosted an appreciation dinner at the Eden Rock Establishment in Kingston, Jamaica, where all of the mission team members received certificates of appreciation and several gifts.

Melissa R. Marshall, the president of SNPMA-Barry University Chapter and organizer of the medical mission trip said, "The purpose of this trip was to (1) provide medical care to those in need in keeping with the SNPMA tradition of leadership through community service, (2) increase the awareness about the great field of podiatric medicine and (3) create an opportunity for podiatric medical students to obtain vital clinical exposure. These three goals were exceeded and we look forward to continuing this event annually." ❖

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# AAWP Announces Founder's Scholarship Receipts

by Jane Andersen, DPM, Vice President AAWP  
by Holly Sheets, DPM, AAWP Scholarship Chair

Each year, five deserving AAWP student members are chosen to receive a \$1000 AAWP Founder's Scholarship. The students must be a rising senior, maintain a 3.0 grade point average and be active with the organization.

They are chosen based on activities, leadership and academics. This year's scholarship recipients are as follows:

**1. Crystal Kincaid** is a senior at OCPM and was President of AAWP for the 2002-2003 school year. She has volunteered at local Free Clinics and organized food and clothing drives. She is also a member of the Podiatric Association for Diabetes and ACNAS.

**2. Jamelia Taylor-Abrams** is a senior at NYCPM. She is a member of AAWP. She has assisted in blood drives and the Harlem Health Fair. She received her scholarship at the AAWP Annual Meeting at the APMA this August.

**3. Jennifer Flo** is a senior at OCPM. She volunteers at many activities within her school and in her community. At OCPM she



Crystal Kincaid



Jamelia Taylor-Abrams



Jennifer Flo



Adejoke Adediran



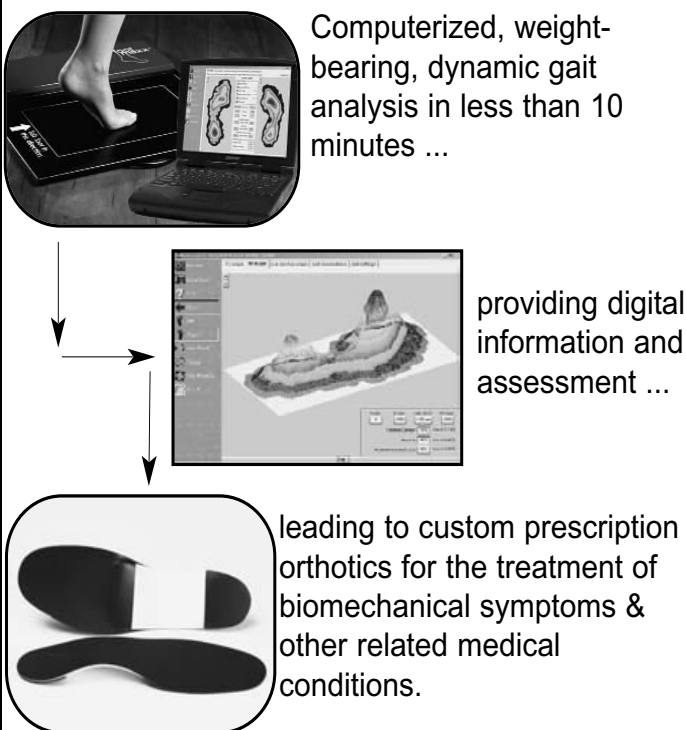
Revonda Jessup

is a tutor and participates in the work-study program.

**4. Adejoke Adediran** is a senior at NYCPM. She is a member of AAWP and APMA. She is on the yearbook committee at NYCPM and a volunteer for many school activities.

**5. Revonda Jessup** is a senior at TUSPM. She is the National President of the Student National Podiatric Medical Association and President of her AAWP chapter. She volunteers at many activities including the Women's Homeless Shelter and the Breast Cancer Walk Foot Screening.

Students may apply as rising seniors each spring. Applications are due June 1, 2004. They should contact their financial aid representative or AAWP chapter president for instructions and applications. Congratulations to all of these successful women. We look forward to having them as AAWP members and leaders for years to come. ❖




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# Heel Pain in the Athlete

by Melinda R. Reimer, DPM

**H**eel pain is one of the most common pathologies seen in the athlete. This article will go over the differential diagnoses and give the practitioner a base of information from which to use as a reference in evaluating patients involved in an exercise program or competitive athletics.

Pain involving the heel can be acute or chronic, involve one region of the heel, and may also be referred to other areas of the lower extremity.

The calcaneus is bordered by a plantar fat pad which contains fibrous septae to help absorb shock. Multiple insertions, including the tendoachilles, intrinsic muscles, and plantar fascia are also contained here. Neurovascular structures also border the heel medially, laterally, and plantarly.

It is important to assess the type of pain the athlete experiences, when it occurs (during and/or after activity), and movements required during the athlete's specific sport which may aggravate it. Examining the athlete's shoe gear is also key, as this may hold the reason why the injury has occurred and needs to be addressed.

**HEEL PAIN LOCATION.** The source of the athlete's pain must be identified in order to properly treat it. Two main areas of the heel encompass a majority of injuries which athletes experience.

Inferior or plantar heel pain can debilitate the athlete not only during sports, but also during walking and daily activities. The differential diagnosis includes, but is not limited to plantar fasciitis, calcaneal apophysitis (pediatric), plantar fat pad atrophy, entrapment of the first branch of the lateral plantar nerve, and stress fractures of the calcaneus.

Posterior heel pain can be due to retrocalcaneal bursitis, insertional achilles tendonitis, Haglund's deformity, or an acute achilles tendon rupture.

**PLANTAR FASCIITIS.** Plantar fasciitis is one of the most common causes of heel pain. Microscopic tears can occur in the plantar fascia at its origin at the plantar medial tubercle of the calcaneus. Repetitive trauma to the area causes this overuse injury, such as direct impact or sports which cause forceful pushoff. Usually, there is no history of acute trauma.

Physical examination may be positive for tenderness to direct palpation of the plantar fascia origin, especially when the fascia is put under tension when the first metatarsophalangeal joint is dorsiflexed.

Radiographic evaluation may reveal a plantar spur or periosteal reaction at the plantar medial tubercle. Triphasic bone scan will show localized uptake in this area, as well.

Faulty foot mechanics in combination with inadequate shoe gear may be one cause. Examine the athlete's shoes...this includes casual, training, and competitive shoe gear. Make sure the shoe does not flex in the midfoot, as is common with cleated footwear and some training shoes. Shoe companies in recent times have taken to "lightening" shoes by cutting away sections of the midsole in the midfoot region causing the shoe to "break" incorrectly.

Treatment options include the use of a night splint, off-the-shelf or custom orthotics, physiotherapy, stretching, injection, and

addressing problems with the athlete's shoes. As a last resort, cast immobilization or surgical release may be considered. Orthotripsy is an option, but recovery time for this procedure may not make it a good option for the competitive athlete who needs to get back to his or her sport in a timely fashion.

**CALCANEAL APOPHYSITIS.** This is seen in the pediatric population while the growth plate or apophysis is still open. Athletes between 9 and 14 most commonly experience apophysitis. Factors include hyperpronation, equinus and growth spurts causing an equinus influence.

Addressing the etiology is most important. Stretching of the gastrosoleus complex, use of heel lifts or heel pads, orthotics, and increasing heel lift in cleated shoe gear (which commonly have a "negative heel") should help to alleviate pain. Abstaining from uneven surfaces needs to take place to take stress off of the growth plate. This also includes soft ground (such as fields which have sustained rains). Anti-inflammatories, such as children's Advil, may be used as an adjunct for pain control.

**PLANTAR FAT PAD ATROPHY.** Though this is more commonly seen in the older athletic population, it can also be seen in younger athletes. Plantar fat pad atrophy is primarily a clinical diagnosis when other diagnoses have been ruled out. As the life expectancy increases and more of the general population becomes involved in an exercise program to maintain quality of life, this may be seen more often.

Generalized achiness or feeling of a "bone bruise" are the most common complaints. Palpation of the plantar heel reveals "minimal padding" underlying the calcaneal tuberosity.

Use of shoes with better cushioning and thick, soft heel pads can be helpful. No surgical option is available for fat pad atrophy. Past studies of collagen injection for fat pad atrophy have concluded that injection of collagen brought short-term failure.

Devices available include Viscosots and equivalents, as well as Tuli's heel cups.

**ENTRAPMENT OF THE FIRST BRANCH, LATERAL PLANTAR NERVE.** Baxter's nerve, or the first branch of the lateral plantar nerve, needs to be considered in athlete's with plantar heel pain, especially those who don't respond to conservative treatment for what is considered to be plantar fasciitis. The athlete may complain of a burning sensation or distal or proximal radiation of pain along the course of the nerve.

The nerve branches at about the level of the medial malleolus and runs distally between the abductor hallucis and quadratus plantae. This pathology is estimated to be present in 10 to 15% of patients who complain of proximal plantar fascia pain.

Pain is produced when the proximal abductor hallucis is palpated. It is not uncommon to have a loss of sensation along the distal nerve course.

Nerve conduction velocity tests may be helpful in diagnosing entrapment. Expertise of the neurologist performing the test and body type of the patient (such as obesity) may limit usefulness of the study.

Conservative treatment is the same, as that for plantar fasciitis. Surgical correction may be required, which addresses decompression.

## **STRESS FRACTURE OF THE CALCANEUS.**

The calcaneus is primarily made up of cancellous bone. Stress fractures arise from chronic impact stress and are mainly seen in athletes whose sport requires repetitive heel strike.

Clinical examination may reveal edema, ecchymosis, and severe pain to direct and medial-to-lateral palpation of the posterior calcaneus.

Radiographic evaluation sometimes shows opacity in a linear, diagonal fashion. When x-ray is negative, and stress fracture is a concern, one should concern a triphasic technetium-99 bone scan.

Additional consideration for stress fracture, is the older athlete with a history or concern for osteoporosis. Bone densitometry of the calcaneus is diagnostic.

**RETROCALCANEAL BURSITIS.** Retrocalcaneal bursitis is primarily a clinical diagnosis. Palpating the area just anterior to the achilles tendon insertions is diagnostic.

Treatment may include reducing equinus with a nightplint/stretching, ice, anti-inflammatories, cortisone injection, and reducing any biomechanical influences.

**INSERTIONAL ACHILLES TENDINITIS.** Athletes with achilles tendonitis are generally participating in sports which require forceful pushoff, pivoting, and "cutting" off of the fore-foot causing traction on the achilles tendon.

Pain may be elicited to palpation of the achilles tendon at it's insertion on the posterior calcaneus or at the midsubstance more proximally.

Radiographs are usually negative, but in chronic cases calcification within the distal tendon may be seen on lateral view. A Hernandez view or 90 degree view down on the heel with the patient in "ski jump" position will reveal the extent of the width of the calcaneus involved.

Conservative treatment includes the use of a nightsplint to reduce equinus, stretching, physical therapy (including iontophoresis), heel lifts, orthotics, change in shoe gear, and change in training surface.

Shoes should be checked to make sure the heel counter and/or midsole has not broken down medially or laterally. Due to poor quality control at some shoe companies, shoes may leave the factory with the heel counter improperly adhered to the midsole/outsole. This should be checked prior to purchase.

Recalcitrant cases may require magnetic resonance imaging to assess for tendinosis which may require surgical debridement. Orthotripsy has had a higher success rate with recalcitrant achilles tendon problems versus issues with the plantar fascia.

**HAGLUND'S DEFORMITY.** Haglund's deformity is commonly associated with retrocalcaneal or superficial bursitis. Athletes whose sport requires them to wear a tighter fitting shoe or boot with stiff heel counter may experience problems with prominence of the posterosuperior eminence of the calcaneus. Ice hockey players, figure skaters, and soccer athletes may be seen with a symptomatic Haglund's deformity.

Radiographic evaluation will reveal prominence on a standing lateral view.

Symptomatic relief may be obtained with the use of heel pads, orthotics which address rearfoot varus, dispersive padding in the athletic shoe/boot, padded sock (such as the Silipos achilles sock), NSAIDS, intrabursal injection. As a last resort, surgical intervention includes resection of the posterosuperior eminence of the calcaneus.

**ACHILLES TENDON RUPTURE.** Rupture of the achilles tendon may occur at the midsubstance or at the insertion on the calcaneus. The athlete, post-injury, may complain that they felt being "kicked in the back of the calf." This is more commonly seen in the middle-aged athlete.

Sports which require jumping, running, or sudden push-off, such as tennis and basketball, have been most often seen in combination with this injury.

Edema, ecchymosis, and tenderness to direct and medial-to-lateral palpation are seen. Thompson's test is also diagnostic. Squeezing the calf should cause plantarflexion of the foot. When this does not occur, suspicion for rupture should be considered.

MRI is diagnostic and may be required for surgical planning. Width of the gap between the two ends with dictate the need for end-to-end repair, advancement flap, or recession in combination with end-to-end repair.

In the athlete, this is the only option. Without surgical intervention, push-off power will be limited to less than 20% of pre-injury ability. Estimates for push-off power following surgical repair has varied and is considered generally to be greater than 85%.

**SUMMARY.** The physician, when encountering an athlete with heel pain, needs to accurately assess and come up with the proper diagnosis in order to treat the athlete and get him or her back to sport in a timely fashion.

Identifying the cause, consistency of pain, and understanding requirements of the athlete's specific sport are important, not only for treatment, but also for prevention.

## **REFERENCES.**

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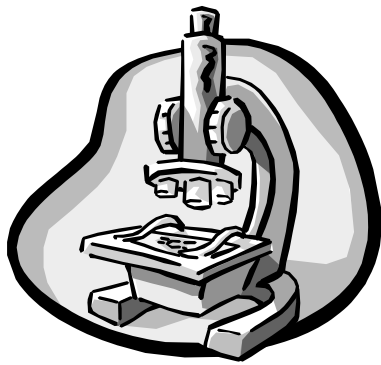
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# How to “Step Up” Assistant Efficiency

by Lynn Homisak, PRT

*“Efficiency... finding a new approach, in the most productive way, in the least amount of time; a concept built by proficiency and organization, with innovation... the architect.”*

That’s my personal concept of efficiency in a nutshell with the idea being how best to get from Point A to Point B and reach a desired outcome. Now, let me put it into real life and illustrate how it can affect your practice. Most times when you give staff a job to do, unless directed otherwise, they are inclined (sometimes strongly encouraged) to do it exactly the way they are taught, which by the way may *not* always be the most effective. Sticking to this one-way method, while considered “workable,” closes off doors of opportunities for change and leads to stagnation on many levels, for the assistant (personally and professionally) and for the practice. It is only after staff is given permission to actually take control of their job and “own” it, that they are motivated to develop new methods that will not only result in the same outcome (maybe even a better one)...but more quickly and with greater satisfaction. It’s called job challenge. Self-determination allows them to become the architect of an all new improved way, through careful re-organization and innovative strategies. I might suggest that rather than observe efficiency from the perspective of *“what can my assistants do to be more productive for me?”* it becomes all the more valuable to ask instead *“what can I do that will give my assistants the necessary space to allow them to be their most productive?”* Be enlightened by the possibilities that can result from giving as opposed to taking.

What’s *key* is understanding that everyone has their own little unique way of arriving at the desired outcome with the emphasis not so much on *how* we arrive there, but that we ultimately arrive. In my presentations, I try to drive this point home by displaying on the screen a number of illusions. Each of these visuals can be viewed one of two ways. As in this illustration below, one person may clearly see a duck at first glance (looking left) while another may see a rabbit (looking right). Who’s wrong? Neither. It’s not a question of “right” or “wrong”—it simply becomes a matter of “perspective.” So, just as the same visual can be seen two different ways, so can two people see different ways to arrive at a similar outcome.



I am asked many times, as the podiatric medical assistant Board member of The American Academy of Podiatric Practice Management, to lend my expertise via lectures and articles about ways in which one can improve staff efficiency. I have discovered, through 33 years experience as a podiatric medical assistant (and more recently from my drastic relocation from one office to another after 32 of those years), that it’s all about empowerment. The efficiency concepts I talk about above are not possible if the doctor does not first put a great deal of trust in their staff or allow them complete ownership in a project. Managing does not mean looking over their shoulder and *telling* them how something should be done. Managing is empowering them to set their

own pace and find their own way. It is important to set goals and desired outcomes for your practice. Then step back, *let go* and give your staff the space they need to implement their own innovative ideas in which to achieve these goals. They *want* to succeed, for themselves and for the practice. Without the freedom to try new things, the positive process known as “efficiency” is stifled. With it, they have an excellent opportunity to grow and produce in a nurturing environment.

I’d like to share with you some ideas that I encourage you to share in turn with your staff. Maybe they are already doing them with great satisfaction; maybe they will take one of these ideas and “go with it”; make it even better. These are only ideas, not solutions. Give them the opportunity to take them in their own direction, increase their own efficiency and make them worthwhile realities for your practice.

1. Make the time to properly train your assistant to where you can delegate more hands-on responsibility which in turn will help to free up more quality patient time for you. Delegating a minute here and a minute there adds up and before you know it, the possibility of seeing one patient more per hour exists. There are many duties you can delegate such as reviewing instructions with the patients for a number of things e.g., prescriptions, pre or post op care, orthotic wear and care, getting injections, casting for orthotics, how to wear a pneumatic boot, injury care, etc. Encourage assistants to make suggestions of other areas that they feel they could help and together discuss the possibilities of making that happen. Keep in mind that allowing your assistants to participate and contribute in this way not only frees up more of your time, but also relates to your assistant a feeling of trust while elevating their professional image to your patients. It’s a win-win all the way around.

2. Review with assistants the proper way to respond to patient questions, such as “Why do you need to take all this information regarding my medical background?” or “Why should I have the doctor make these orthotics for me, when I can get them cheaper at the sports store down the street?” Together, develop a canned speech response which will address patient concerns, but make sure it is rehearsed in such a way that the assistant can deliver the response as naturally as their own name.

3. Encourage assistants to develop whatever new forms are necessary to help them better organize the office. One example might be a form which clearly directs them through certain processes such as obtaining patient insurance verification or a surgery check list to verify contacts and make sure everything is ready to go come the day of surgery.

4. Allow assistants to develop their own pattern in which to organize patient charts, so that everyone knows immediately when opening a chart where to find what. For example, one side might contain all medical information, while the other side all billing info. Because patients seem to always be changing their health insurance, we “mark” the newest copy of their insurance card with a neon-colored sticky note folded over one side. When we open the chart, we don’t need to flip through all the sheets to find their card,

(continued on page 11)

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## AAWP Membership Application

Dues become renewable each July 1st

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College of Podiatric Medicine \_\_\_\_\_ Yr. Grad \_\_\_\_\_

### Membership Categories and fees:

\_\_\_ Active: \$75 yearly / \$125 2 years (Must be an APMA member)

\_\_\_ Associate Member: \$25 yearly

*Please circle one:* Resident, 1<sup>st</sup> year practitioner

\_\_\_ Life Member: \$600.00 (One time fee)

\_\_\_ Friends of AAWP: \$175.00 yearly (Non-AAWP members)

**Make Checks Payable to AAWP and send to: American Association for Women Podiatrists, Inc; Pamela Sisney, DPM; 961 Woodcreek Dr.; Milford, OH 45150**

**\*\*\*Please note that dues will increase July 1, 2004.**

# Spa Seminar May 13-16, 2004

## 25\* CMEs

*by Jane Andersen, DPM  
Vice President AAWP*

**S**ave the date for the next AAWP Scientific Seminar **May 13-16, 2004** at the Fairmont **Scottsdale Princess** in Scottsdale, Arizona. This will be **25** continuing education contact hours\* you'll enjoy—with **hands-on workshops** to compliment the cutting edge lectures.

Topics may include podopediatrics, radiology update, advances in wound care and considerations in perioperative medical management.

The Fairmont Scottsdale Princess is a AAA Five-Diamond world-class resort with two golf courses, four pools, seven tennis courts and the Willow Steam Spa (named as one of the best spas in the North America). It is just 25 minutes from the Phoenix airport. For more information, visit [www.fairmont.com](http://www.fairmont.com).

The seminar will be offered to AAWP members at a **reduced rate of just \$298**. This is an outstanding value for 25 continuing education contact hours\*. We have also secured an incredible rate of \$229 per night (single/double) at the Princess. To reserve your room, call 1-800-441-1414 and mention AAWP. To register for the seminar portion, contact Dr. Colleen Schwartz at [drschwartz@aawp@sbcglobal.net](mailto:drschwartz@aawp@sbcglobal.net).

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\*Contact hours pending.

## Karyn Sallus, DPM Wins Spa Seminar!

**C**ongratulations to Karyn Sallus, DPM for placing the winning bid at the APMSA Silent Auction. AAWP donated a seminar tuition for the upcoming Arizona Spa Seminar to the APMSA. All funds raised at the APMSA Silent Auction, which is held in conjunction with the APMA Scientific Seminar, are donated to the Fund For Podiatric Medical Education (FPME). ❖

## Treasurer's Report

*by Pam Sisney, DPM*

AAWP currently has approximately \$20,000 in our checking account, \$3,000 in our scholarship fund and \$19,000 in a CD.

AAWP has given \$5,000 in scholarships for the year, contributed \$2,500 to the Podiatry Political Action Committee (PPAC) and \$2,500 to the Fund for Podiatric Medical Education (FPME), on behalf of the membership of AAWP. These numbers mean that approximately one-third of our funds have been funneled back to our profession. Thank you for your continued support of AAWP. ❖

# Re-Thinking Neuropathy, Neuromas and Tarsal Tunnel Syndrome

by Serrina Yozsa, DPM

We all have patients with neurogenic symptoms, but our diagnostic and treatment paradigms have been on the horizon of change. Diagnostic examinations have far surpassed a Semmes Weinstein Monofilament and tuning fork; etiologies are more numerous than previously thought and we have more treatment options available.

Historically, a “Morton’s Neuroma” was thought to be a perineural fibromatous mass in the third innermetatarsal space. However, the true definition of a neuroma is a nerve, after having been transected, by Wallerian regeneration, grows a bulbous mass due to high concentrations of lipid deposition. Furthermore, patients with “neuromas,” which are actually entrapment neuropathies of the third innermetatarsal space, often also have tarsal tunnel syndromes, due to compression causing a distal radiation of pain. Entrapment results from chronic, repeated injuries to a nerve in its natural anatomical compartment that has become too narrow to allow the normal atraumatic motion of the nerve.<sup>12</sup>

A healthy, intact, non-diseased nerve should not elicit severe tenderness with palpation. After you diagnose a neuroma/entrapment neuropathy, examine your patient proximally. Palpate the tibial nerve and its medial calcaneal branch to the medial heel. If the patient winces or demonstrates a sign of pain, tap or percuss the nerve. A positive Tinel’s sign is an indication of neuropathy, by definition.

Does the patient have entrapment due to shear compression and pronation causing numbness, tingling, burning or cramping in the heel, foot or toes causing a tarsal tunnel syndrome? Have you looked for space occupying lesions, such as a ganglion? Or, is there a metabolic etiology at hand? Diabetes causes neuropathy at day one of diagnosis, which means any delay in diagnosis further delays treatment. Syndrome X, Metabolic Syndrome and Insulin Resistance Syndrome should also be ruled out before determining your etiology and correct treatment. The definition of metabolic syndrome has been described in the *Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults* as 3 or more of the following: (1) waist circumference >102 cm in men and 88 cm in women; (2) serum triglycerides level of at least 150 mg/dL; (3) high-density lipoprotein cholesterol level of less than 40 mg/dL in men and less than 50 mg/dL in women; (4) blood pressure of at least 130/85 mm Hg; (5) fasting serum glucose of at least 110 mg/dl.<sup>3</sup>

In patients with neurogenic findings, multiple patients have been discovered with undiagnosed diabetes, Syndrome X, Insulin Resistance and other metabolic diseases by a few simple routine laboratory tests. A fasting blood sugar level will often miss a diagnosis. Order a Fasting BSL, Two hour Glucose Tolerance Test, HgA1C, Lipid Panel and a Serum Insulin. Often, what you see will amaze you. Many patient’s sugars shoot sky high when challenged with a sugar bolus, never seen on their routine exam. Furthermore, it is now well documented that high lipids and high sugars also are causing neuropathy. You can then work with the primary care physician for appropriate metabolic treatment, as Syndrome

X implies that the consequences of hyperinsulinemia and glucose tolerance (metabolic, hemodynamic and vascular sequelae) should commence earlier in the patient’s lifetime than previously known.<sup>4</sup>

Additionally, quantitative neurosensory testing measuring 1 and 2 point discrimination with a computer is now available to detect neuropathy years before a Semmes Weinstein Monofilament picks up the diagnosis. Neuropathy begins at 20 gm/mm<sup>2</sup>.

Additionally, quantitative neurosensory testing measuring 1 and 2 point discrimination with a computer is now available to detect neuropathy years before a Semmes Weinstein Monofilament picks up the diagnosis. Neuropathy begins at 20 gm/mm<sup>2</sup>. Surgical treatment for tarsal tunnel syndrome, entrapment neuropathy of the third innermetatarsal space and true neuropathies are now being surgically decompressed under loupe dissection. The paradigm changes our thought process with “Morton’s neuromas,” because decompression of the third innermetatarsal ligament is now possible with simple instrumentation. Koby Surgical has recently developed a very easy system. A small incision is made between the toes, the ligament is identified, isolated, protected and transected, thus decompressing the “Morton’s neuroma.” Remember, removing the nerve is creating a true neuroma. This is “carpal tunnel surgery” between the toes. This is a novel concept and very easy to perform.

When a nerve has increased pressure on it, its blood flow decreases. This causes the nerve to alter its transmission yielding tingling and numbness. The symptoms can be worse after standing or walking. Cramping in the foot can occur as the muscles lose their nerve supply. If just the calcaneal branch is affected, the symptoms may seem the same as a bone spur or plantar fasciitis.

Non-operative treatment is to take pressure off of the posterior tibial nerve and its branches by use of an orthotic, as is done with a splint for the hand. Changing activities, anti-inflammatory and other medications for treating “neuropathic pain,” local nerve injections with lidocaine/dexamethasone and stockings to control swelling can help prevent surgery. Studies have shown that acetates can be damaging to the nerve – so be careful. When conservative treatment is exhausted and spine symptomatology is ruled out, surgery may be warranted. Proper decompression of the tarsal tunnel requires surgical dissection with magnification, with or without neurolysis and opening of the medial and lateral plantar tunnels. The branching pattern of the medial calcaneal nerve is visualized, dissection is followed into the foot, thus relieving the pressure on the heel and restoring sensation to the foot. Distally, decompression is performed between the toes. Many times, as is often the case with diabetics, other nerves can be affected and release of these nerves may be performed. In patients with ulcers, vascular blockages can be corrected at the same time as surgery, thus aiding in healing of a longstanding wound(s). ❖

(Endnotes)

<sup>1</sup> Dyck PI, Giannini C, Lais AC. Pathological alterations of nerves. In Dyck PJ, Thomas PK, Griffin JW, et al (eds): *Peripheral Neuropathy*, ed 3. Philadelphia, WB Saunders, 1993, pp 514-595.

<sup>2</sup> Stewart JD, Aguayo AJ. Compression and entrapment neuropathies. In Dyck PJ, Thomas PK, Lambert EH, et al (eds): *Peripheral Neuropathy*. Philadelphia, WB Saunders, 1984, p 1435.

(continued on page 11)

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# AAWP Sponsors Cadaver Lab at APMA

by Jane Andersen, DPM  
Vice President AAWP

**A**AWP sponsored a Surgical Skills Workshop and Cadaver Lab, at the APMA Scientific Seminar August 8, 2003 in Washington, DC. This is the second such workshop at the APMA National meeting sponsored by the organization. Twenty-four surgeons participated from around the country, with two surgeons per cadaver leg. Six companies sponsored the workshop stations. They included the following:

**Vilex Screws** demonstrated a closing base wedge bunionectomy with their cannulated screw system. The instructor was Dr. Judith Cappello.

**KMI** demonstrated the subtalar arthroereisis technique with the MBA Implant. The instructor was Dr. Mary Crawford.

**Koby Surgical** demonstrated a new technique for plantar fascial release and nerve decompression. The instructor was Dr. Serrina Yosza.

**KCI** demonstrated vacuum assisted wound closure with the Wound Vac. The instructor was Dr. Colleen Schwartz.

**Wright Medical** demonstrated a first metatarsophalangeal joint implant. The instructor was Dr. Gina Saffo.

**Arthrex** demonstrated a lateral ankle stabilization with their biotendonesis system.

The instructors were Dr. Larry Kosova and Dr. Jane Andersen.

The workshop was a critical success in the eyes of both participants and sponsors. Look for more workshops in the future sponsored by AAWP.

Special thanks to **Universal Footcare Products** for sponsoring the workshop and providing supplies! ❖

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## How to “Step Up” Assistant Efficiency (continued from page 7)

we all know it's the one that sticks out with the neon note attached to it.

5. Have a referenced list of “most used” prescriptions handy, so that assistants can write them up for you as they hear you discussing treatment plans with the patient.

6. Make it a point to have assistants review all patient charts prior to beginning the day. Stopping to request a lost test result or failure to contact a patient whose referral is not up to date can severely interrupt patient flow. Knowing in advance what the schedule holds (patient-wise) will allow everyone to better plan their day.

7. Encourage assistants to ergonomically and effectively rearrange their office space to where things are more convenient and comfortable for them...e.g., have the things they use most often, such as the copy machine or the shredder placed in close proximity to their desk. Arrange things so that they are within easy reach and always find ways to save steps whenever possible!

8. Encourage them to make folders for items that they use on a routine basis; label them however they wish and place them where they are easily accessible. This keeps loose paperwork off the desk and organized. I use color coded folders and place them in a graduated file holder on top of my desk for easy viewing.

9. Save time when a new patient presents to your office by mailing them a registration form ahead *of time* to fill out at home. (We've even incorporated an address label right into the form itself, so when we fold it up to mail it, the patient's name and address are visible.) Now, in addition to being able to see this patient on time (instead of waiting for them to fill it out in the reception room), it also allows them to provide a more concise list of their meds, certain telephone numbers they might not have with them and it gives the older patient the ability to have someone at home help them fill it out.

10. Keep a dated telephone log to record all incoming and outgoing telephone messages. This also serves as a reminder to document things patients say to you, a reference for phone num-

bers not yet recorded and it keeps all messages together, eliminating the clutter of scattered post-it notes.

I know many doctors who are afraid to “let go” and delegate duties and responsibilities to their assistants. They ask me, “Why should I do that? Why should I give my assistant so much leeway? *What's in it for me?!*” My best response to them is a quote I heard recently, and have since used it to conclude every one of my lectures because I so strongly believe it to be true on so many levels:

“Hire the best. Pay them fairly.

Communicate frequently. Provide challenge and rewards.

Believe in them. Get out of their way....

And they will knock your socks off!”

That's what's in it for you! ❖

[Lynn Homisak, PRT, is a team partner in *Secrets of Success* (S.O.S.) Healthcare Management Solutions, LLC and a member of the Board of Trustees of the American Academy of Podiatric Practice Management (AAPPM). For more information about the AAPPM, please visit their website at [www.aapmm.com](http://www.aapmm.com) or email [info@aapmm.com](mailto:info@aapmm.com).]

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## Re-Thinking Neuropathy (continued from pg. 10)

<sup>3</sup> Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adults Treatment Panel III). Bethesda, MD, National Institutes of Health; NIH Publication 01-3670, 2001.

<sup>4</sup> Weiswasser JM, Nylen E, Arora S, et al: Syndrome X and Diabetes: What is the Mystery? Seminars in Vascular Surgery, Vol. 15, No 4 (December), 2002: pp 216-224.

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# BUSGMS Awards 2003 Scholarships

by Nicklya Harris, BUSGMS

Each year at Barry University, active members of AAWP are awarded for their achievements and scholastic ability. For the past several years, the chapter has awarded scholarships based on financial need and academic diligence. This year, the four scholarship recipients are Sara Phelps, Kathren McCarty, Lisa Dodenhoff, and Joanne Balkaran.

**Lisa Dodenhoff** is a senior and served as the 2003 treasurer. She ranks high scholastically in her class, is a presidential scholar, and was one of 3 members of AAWP who received perfect event attendance certificates at the end of the year dinner banquet.

**Kathren McCarty** is a junior and active member of AAWP. She currently serves as this year's FPMSA President, a result of her diligent work last year as FPMSA vice-president.

**Joanne Balkaran** was also an active member of AAWP this last year, and has now been granted the position of treasurer for the upcoming year. As a sophomore, she also serves as the sole student FPMA Liason for the state of Florida.

Last but not least, **Sara Phelps** is a sophomore who took on a very active role in AAWP this year, making the most sales at this year's annual Valentine's Day Fundraiser. It's no wonder that she ran unopposed and is the 2003-2004 president of Barry's AAWP.

All these ladies were very deserving, and congratulations are due! ❖

# Support AAWP Sponsors

by Colleen Schwartz, DPM  
Executive Director, AAWP

Through partnership with healthcare corporations, the American Association for Women Podiatrists, Inc. has organized educational programs, published quality newsletters and provided scholarship opportunities for its members and the podiatric community at large. We extend our heartfelt thanks to the following companies for their AAWP support in 2003:

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# Practice Business Plan

by Marybeth Crane, DPM

All of us had to draw up a business plan to obtain our small business loan when we first opened our doors. Most of us have not updated them since that time and probably do not even know where they are. You need a plan! How would you like to see the business grow? What size is busy enough to add an associate? Where do you see your practice, and (separately) yourself, in 5, 10, 15 years? What is your exit strategy?

You cannot put together a marketing plan without an idea of goals for the plan and the practice as a whole. Some people would like to stay in one location, make \$X/year and never have an associate. These people just need to figure out how many new patients/month will generate \$X/year. Others have grander visions of multiple offices, multiple associates, and \$XXX/year. This group needs to identify a stepwise plan to achieve these goals over a 5 or 10-year period.

**REMEMBER THAT YOU HAVE TO DEFINE WHAT IT IS YOU CONSIDER A SUCCESS BEFORE YOU CAN FIGURE OUT HOW TO GET THERE! ❖**

*\*Editor's Note: This article is part of series. Previous practice management articles by this author can be viewed online in prior editions of the newsletter at [www.aawpinc.com](http://www.aawpinc.com).*



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