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Canadian Federation of Podiatric Medicine

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Message from the President

by Dr. Helen Rees

"YOU ARE THE AVERAGE OF THE FIVE PEOPLE YOU SPEND THE MOST TIME WITH."

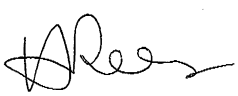
The change of seasons is very apt as we are changing seasons, so to speak, with CFPM. As you know, Stephen Hartman stepped down as CEO after almost 20 years helming our association. Fortunately, he remains on the Board of Directors and we can count on him for historical information as well as continuing to be a crucial voice for podiatry and chiropody. We cannot mention Stephen's contributions without mentioning Cindy Hartman's role in CFPM's ongoing success. We thank them both for how they have formed our association, and their contributions moving forward.

The Board of Directors, Staff and myself as President work to serve you, our members. All of us at CFPM are acutely aware of the insurance issues faced by our members in Nova Scotia and Newfoundland. We are working hard at resolving these issues to ensure that members receive coverage from all insurance companies. We have a committee devoted to resolving this specific issue, but it's an ongoing project to continue to develop positive relationships with insurance companies to ensure that Chiropodists and Podiatrists receive the correct coverage to ensure patient-centred care. If you are interested in joining the Insurance Committee, please contact the office directly at office@cfpmcanada.ca. We are always looking for new volunteers and opportunities to engage our members.

We endeavour to create meaningful continuing education opportunities, like our annual conferences, workshops and programs. This Fall's Conference explores many facets of our profession with an impressive lineup of international speakers to inspire and educate. Please feel free to visit our website for more information or to register for the Conference taking place November 8-10, 2018 in Niagara Falls. The Assistant's Program continues to evolve and we take great pride in helping shape the profession through the creation of this certification. More information on the program can be found on our new website, www.podiatryinfocanada.ca. We have taken great care and consideration with the revamped website with member experience being the driving force of its new design and usability.

The strength of CFPM comes from our members. We all have the common goal to provide exceptional care for our patients and to champion our industry as a whole, and for that, I thank you.

All the best,



Dr. Helen Rees
President, CFPM

Legacy of CFPM

by Dr. Brian Johnson

As a faculty member at what is today the Michener program. I first met Stephen Hartman as a student. At that time I had no idea of his potential and for his future achievements.

Where, as most students graduate and go on to their new podiatry careers, Stephen seeing that the new Ontario chiropody profession was in disarray and without direction. He decided to do something about it.

He and others formed today what is known as the Canadian Federation of Podiatric Medicine. The largest and most influential podiatry association in Canada. In just under 20 years of hard work Steve, his wife Cindy and his office staff have succeeded in growing an organization that is today internationally recognized.

In 2016 Steve spoke and represented the CFPM, at the UK podiatry convention in Glasgow and I the following year in Liverpool. There were no other North American speakers. Steve has forged a close relationship with the UK profession. In my opinion the UK has a closer relationship with the CFPM then with any other North American Podiatric Organization.

In his tenure's as President and CEO he has handled many difficult situations and legal threats very professionally. He and Cindy have put together all the CFPM conventions, both in Canada and abound.

This has all been achieved with the CFPM's ongoing financial growth and security.

This year Steve, Cindy and his staff have helped put in to place a management organization to ensure the CFPM's ongoing continued success and growth allowing them to focus on their busy Kitchener office.

We are all very fortunate that he will continue to serve on the executive. We will therefore not be losing his huge knowledge base and history of the organization.

Thank you to my friends Steve and Cindy for a job well done. Thank you for Steve Hartman's CFPM, we would not be here without you.

Dr. Brian Johnson
Director, CFPM Board

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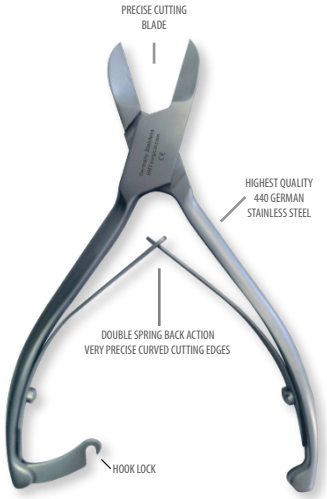

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Message from the Executive Director

Dear CFPM Members,

I'd like to formally introduce myself to you now that things have settled here at the National CFPM Office. My background is grounded in project management and association governance. I plan to bring my skills and knowledge to work in tandem with our skilled staff and the Board to drive CFPM forward, and to better serve you, the membership. As you are aware, there has been a strategic change in management and operations at CFPM. After a carefully planned selection and evaluation process, the Board chose a new direction by hiring an Association Management Company, also known as an AMC. What this translates into is a team of experts well versed in membership, certification, event management, chapter and volunteer relations as well as the strategic management of a member-based organization.

Your CFPM team is a group of people with a passion for service, continuous improvement, and always committed to offering quality products and services for our members.

Since the last correspondence from CFPM President, Helen Rees, was sent out, we now have a full team to serve all of your needs. Please find below complete staff names and their contact information.

We are working diligently to deliver a fantastic, new Conference experience and I look forward to connecting with you there. The 2018 Canadian Federation of Podiatric Medicine 19th Annual Clinical Conference on November 8-10 at the Sheraton on the Falls Hotel, Niagara Falls, ON is bringing the focus back to you, the members. This year's program offers chiropodists, podiatrists, office staff and other health professionals the opportunity to attend a dynamic, educational conference that is essential to your professional development. Bring your assistants for sessions specifically designed for their professional development, and sign them up for the exclusive CFPM Assistant's Program.

Please do not hesitate to reach out to us at any time. We would love to hear from you.

All the best,

Terra Belanger,
Executive Director

CFPM Staff

Terra Belanger
Executive Director
Terra is responsible for all facets of the member experience and organizational programs. She can be reached at 647-243-3552 and terra@cfpmcanada.ca

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Revisiting Laser Treatment: Does It Have A Viable Role In Onychomycosis Treatment?

by Jodi Schoemhau, Gold DPM

While doctors have been using lasers to treat onychomycosis for more than 10 years, there has been some controversy as to whether this is a viable option for patient care. There is limited supporting documentation and research that can quantify outcomes with lasers. I have not published any of my data but what I do have is 15 years of experience with the use of a 1064 nm Nd:YAG class IV laser.

I will first start by saying that not all lasers have equal power. Unless you have a class IV Nd:YAG laser, Q switch or other laser that can produce enough energy to penetrate the nail tissue with selective thermophotolysis, the outcomes may not be comparable.

At the first consultation, I quickly categorize the nails as mild, moderate or severe. Mild cases present with superficial white onychomycosis, minimal lysis and discoloration that occupies less than 25 percent of the nail. Nails that have moderate involvement have discoloration that occupies up to 60 percent of the nail and there is visible lysis and mild thickening. Severe onychomycosis includes lysis approximately 75 percent in the proximal portion of the nail, discoloration affecting more than 60 percent of the nail, subungual debris and thickening.

I find the best outcomes with laser treatment are for patients with mild and moderate involvement. In severe cases, I honestly tell the patient to either live with the condition or I recommend a medical pedicure to keep the thickening under control. We can treat the nail with severe onychomycosis with lasers but it will take extreme diligence with a possible recommendation of a nail avulsion and treating the nail with combination therapy as it grows out.

In all cases, I do recommend a home regimen to include a home antifungal sweep of the shower, carpets and any open sandals. I also recommend the patient file the nail on the top and the tip with subsequent soaking. Patients do this twice a week.

Our office also provides medical pedicures. There is a significant difference in clinical outcomes in the patients who commit to having medical pedicures and patients who do not. A medical pedicure provides an in-depth cleaning of the skin and the nails including debridement, evacuation of any subungual debris and treatment with a topical antifungal. I also address the use of digital offloading with spacers and orthotics for nails that are at higher risk for microtrauma in shoes, which can lead to an increased incidence of fungus.

Combination therapy is required to be successful with the treatment of nail fungus. I place patients on a treatment program with specific protocols and adherence to that program is imperative for positive outcomes.

With mild cases of onychomycosis, I recommend a topical antifungal medication and at least three laser treatments spaced every two weeks apart. After the laser treatments are complete, I recommend continuation of the topical medication for at least six months.

For moderate cases of onychomycosis, I will include antifungal treatments spaced three weeks apart, topical medication and medical pedicures. I typically jump-start the program with a short course of oral medication.

I address severe onychomycosis with oral medication, lasers, topical medication and medical pedicures. Again, it may be prudent to start with a nail avulsion and provide treatments as the nail grows in.

I also recommend advising the patient on a maintenance program and that nail fungus is often a recurrent issue.

My conclusion on laser treatment for nail fungus is that outcomes can be very rewarding if you offer the treatment to the appropriate patients. Combination therapy with topical medication and medical pedicures for debridement are imperative as is providing treatments with a strong laser.

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How Antibiotics Can Affect Achilles Tendinopathy in Athletes

John Mozena, DPM, Clint Jones, DPM, and Vineet Mehndiratta, DO

These authors consider the risk-benefit ratio for using antibiotics in patients with Achilles tendinopathy, especially athletes.

Over the last several years, more people of all ages have been playing sports, which has led to an increasing number of sports injuries, including tendinopathies. Achilles tendinopathies have been problematic, especially in athletes participating in all type of sports. However, these injuries are not related to athletes alone as one-third of all Achilles tendon issues occur in non-athletes.[1]

The Achilles tendon is one of the more frequently injured tendons due to its "whipping action" during use. Many factors appear to be involved with this problem, including changes in training patterns, shoe gear, training surfaces and any type of speed work. These problems can lead to an overloading of the tendon, resulting in breakdown, inflammation and even rupture. There are many other factors that can lead to breakdown of the tendon as well. The one we have been concerned about most recently is antibiotic use.[1]

Tendons are unique in that they transmit forces of the muscle to the bone. A tendon has mechanical strength, flexibility and elasticity. The tensile strength of a tendon is related to its thickness and its collagen content. The stress on the tendon during athletic activity can be tremendous.[1]

Since the discovery of penicillin in 1928, researchers have developed countless new classes of antibiotics to treat a wider variety of infections. These different classes (i.e., penicillins, cephalosporins, aminoglycosides, macrolides, tetracyclines, fluoroquinolones, etc.) work in different ways. Penicillin and cephalosporins interact similarly by altering cell membranes. Fluoroquinolones work by inhibiting DNA gyrase, resulting in improper DNA synthesis. Many antibiotics work to inhibit ribosomal subunits, which is important for protein synthesis. Of these antibiotics, aminoglycoside and tetracyclines act to inhibit the 30th subunit (a section of the ribosome genetic code used in protein synthesis of the bacteria) while macrolides inhibit the 50th subunit.[2–6]

A Closer Look At The Research On Tendon Ruptures And Antibiotic Use

Physicians began noticing problems with Achilles tendinitis and rupture in the mid-1980s with people taking antibiotics. Fluoroquinolones was the first antibiotic group recognized as having a relationship to tendinopathies. The mechanism of tendon injuries is not well understood although we know quinolones exhibit an affinity for connective tissues. The hypothesis is that quinolones disturb the prolonged interaction between cells and matrix by chelating divalent ions, leading to breakdown. Studies have attributed 2 to 6 percent of all Achilles tendon ruptures to quinolones.[7–9] The first reported case of quinolone-related Achilles tendinopathy was in New Zealand in 1983.[10] Researchers have now shown fluoroquinolones triple the risk of tendon rupture and the risks increase with age as well.[7–9]

Over the years, there have been increased reports of tendon rupture and tendinitis with other antibiotics, such as tetracyclines, doxycycline and macrolides (i.e. azithromycin). The Food and Drug Administration (FDA) reports that approximately 0.25 percent of patients with Achilles tendon rupture have experienced this side effect with azithromycin including tendon rupture and a staggering 7 percent of those that experience tendonitis with tetracycline.[9] Typically, in younger patients, these side effects are not as severe and they also recover better. However, in elderly patients, the side effects can be quite debilitating, leading to decreased function as well as increased morbidity. Fifty percent of those patients having tendinopathies due to antibiotic use are over the age of 60. These percentages may be smaller in comparison to fluoroquinolone use in patients with tendinopathies but the fact remains that tendon injury, including rupture, can occur with other antibiotics.[8–11]

The use of antibiotics can also create an inflammatory response. Through this response, there may be a buildup of toxic substances (for example, free radicals) that may damage tendon cells as well. Another proposed mechanism of inflammation is through the inhibition of metalloprotease, which is known to occur with the use of doxycycline. Despite the many different

mechanisms theorized, there is no clear-cut answer and the mechanism of inflammation is most likely multifactorial. While researchers have not determined the mechanism behind the side effect, these injuries tend to occur in individuals who have previously overused or injured their tendons in the past. These patients may include athletes or the elderly.

Athletes are a high risk population for the use of antibiotics. This is especially the case for older athletes. The routine use of antibiotics has been associated with tendon injuries, cardiac arrhythmias, diarrhea, cartilage issues and decreased performance. Athletes use oral antibiotics two times more often than non-athletes . The theory is that sports physicians prescribe a higher rate of antibiotics in hopes of getting the athlete to return to activity as soon as possible. Furthermore, researchers have proven that concurrent corticosteroid use puts individuals at an increased risk.[3–5,9–15]

Case Study One: Addressing Achilles Tendinopathy In A Marathon Runner Using Azithromycin

A 60-year-old 25-time marathoner and 50-time triathlete reported to our office with a painful left Achilles tendon. The athlete had previously suffered from Haglund's disease of the right heel but had never experienced any pain in his left foot or ankle. The pain started on a normal workout while the patient was on a six-mile run. The pain became so intense he had to stop halfway through the run and walk home. The patient had done a half Ironman triathlon three weeks earlier and had developed a sinus infection, which his primary care physician treated with azithromycin. Approximately one week after finishing the antibiotics, he noticed a swelling in his left Achilles tendon measuring 3 cm in length by 1 cm above the tendon insertion.

Our diagnosis was Achilles tendinopathy secondary to antibiotic use. His treatment consisted of cross training, heel lifts, stretching and anti-inflammatories. The patient slowly went back to his normal training program over the next month.

Case Study Two: When Ciprofloxacin Contributes To Tendinopathy

A 63-year-old man with a history of taking ciprofloxacin for four months for a urinary tract infection presented to the clinic for treatment of Achilles pain on the right side. He noted the pain had increased since he started taking the medication.

With a diagnosis of antibiotic-induced tendinopathy, the patient received a treatment that controlled the symptoms. Over time, the patient developed concomitant plantar fasciitis and a plantar fibroma with Achilles equinus on the ipsilateral limb. This also required ongoing treatment.

In Conclusion

The risk/benefit ratio is something to consider with every drug, particularly antibiotics. Antibiotics certainly have a relationship to tendinopathies and this is a pertinent consideration for the physician when prescribing them.

The concern we have is that tendinitis and tendinopathies have been under-reported in patients with antibiotic use and researchers are currently only looking at Achilles tendon ruptures in this patient population. We also contend that one can extrapolate that all antibiotics may play a role in tendinopathies and further study may be required for this particular issue. We hope these case studies have brought to light the importance of being aware of antibiotic use and the possibility for Achilles tendinopathies, especially in athletes and those over the age of 60.

Dr. Mozena is in private practice at the Town Center Foot Clinic in Portland, Ore. He is a Fellow of the American College of Foot and Ankle Surgeons, and is board certified in foot and ankle surgery. He is a Clinical Assistant Professor of Surgery at the Western University of Health Sciences.

Dr. Jones is in private practice at the Town Center Foot Clinic in Portland, Ore. He is board certified in foot surgery. He is a Clinical Assistant Professor of Surgery at the Western University of Health Sciences.

Dr. Mehndiratta is currently a resident in family medicine with Central Washington Family Medical in Yakima, Wash.

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Is Blood Flow a Significant Factor in Patients with Charcot Neuroarthropathy?

by John Mancoll, MD, Alex Webb, BS, and William Grant, DPM, FACFAS

There is a prevailing perception that patients with Charcot neuroarthropathy are distinctly different from other patients who present with other diabetes-related foot problems. Specifically, in comparison to patients with diabetes who do not have Charcot foot/ankle deformities, some believe Charcot patients have a "normal vascular exam."[1] Not only do some physicians believe patients with Charcot neuropathy have normal blood flow but some consider increased local blood flow to be a hallmark of Charcot neuroarthropathy.

Diabetic foot wounds are a very challenging problem but when one considers the subset of patients who have a Charcot deformity, the problems only seem to be magnified. Charcot neuropathy remains a poorly understood pathophysiologic process. Risk factors associated with soft tissue defects in patients with diabetes include neuropathy, diminished blood flow and local trauma.[2]

While it is generally accepted that altered blood flow is a significant part of the etiology for most diabetic foot wounds, researchers believe the opposite to be true in patients with Charcot neuropathy.[3,4] Wukich and colleagues presented a series of patients with Charcot neuropathy who did not have significant peripheral vascular disease (PVD).5 In their population of Charcot patients, the need for revascularization was reduced by 82 percent in comparison to those with diabetes only. Indeed, there is a general perception that patients with Charcot not only have normal blood flow but actually have augmented blood flow due to the inflammatory nature of Charcot neuropathy.[1]

We challenge the assertion that vascular disease is minimal in patients with Charcot. Accordingly, with this article, we would like to review our experience with Charcot neuropathy, determine if revascularization is necessary and see if staging of Charcot disease is a factor in revascularization.

What One Unpublished Study Reveals

The primary goal with our unpublished study was to see if patients who have been diagnosed with Charcot neuropathy and have abnormal bedside Doppler exams also have any clinically significant PVD. The secondary goal was to look for identifiable patterns of vascular disease within this patient group. We reviewed the charts of all patients with abnormalities noted on bedside exam.

A retrospective chart review of surgical patients over the last 12 months identified 34 patients with abnormal bedside Doppler exams. The mean age of the patients was 55 years old and 64.7 percent were men. Among those patients, 79.4 percent had unilateral disease with 53 percent involving the left foot and 26.5 percent involving the right foot. Bilateral disease was present in seven of these patients.

We then stratified patients by Eichenholtz's PVD classification.[1] Thirteen of the 34 patients had stage I PVD, 16 patients had stage II PVD and three patients had stage III PVD. Within each stage, 46 percent of stage I patients, 18.7 percent of stage II patients and 50 percent of stage III patients had severe PVD.

We sent all patients with abnormal Doppler signals for additional vascular evaluation. We measured the ankle brachial index (ABI) in 29 patients and also obtained toe pressure measurements in 76 percent of the 34 patients. This was due to limitations in interrupting ABI results with the most common reasons being non-compressible vessels and falsely elevated results. Based on the outcome of the non-invasive studies, 16 patients went on to have arteriograms. Twenty-two of the 34 patients had clinically significant PVD. Ultimately, seven patients needed intervention, five of the seven patients had an endovascular procedure and two patients needed vascular bypass. We identified the location of vascular obstruction in all patients. Eighteen patients suffered from multi-level disease while only one patient had a single lesion. The most commonly involved vessels were the anterior tibial and dorsalis pedis arteries.

Further Insights On The Impact Of Charcot Neuropathy

Diabetes is a worldwide epidemic affecting over 30 million people in the United States alone.[6] An estimated 1 to 7.5 percent of all patients with diabetes will also develop Charcot neuropathy. Given Charcot's clinical similarities to osteomyelitis, there is a perception that this incidence is underestimated due to misdiagnosis in

early stages.

The hallmark of all patients with diabetes is hyperglycemia. It is well established that the longer the patient's blood glucose levels are elevated, the more destructive diabetes can be. We know that persistently elevated blood glucose levels have significant deleterious effects on both nerves and blood vessels. The mechanism by which this happens is partially understood. Authors have shown that continually elevated levels of blood glucose levels contribute to endothelial cell dysfunction and smooth cell abnormalities.[6] Additionally, we see decreases in endothelium-derived vasodilators that lead to vasoconstriction, increased atrial stiffness and, ultimately, endothial dysfunction.[7]

Further, hyperglycemia is associated with an increase in thromboxane A2 levels.[8] Thromboxane is a potent vasoconstrictor and can cause platelet aggregation. The net result is an increased risk for plasma hypercoagulability and clotting. We also know patients with diabetic foot ulcers have higher pro-inflammatory markers, such as adiponectin, resistin and interleukin-6 levels, in comparison to patients without ulcers.[9]

It would be nonsensical to assume that the presence of hyperglycemia in patients with Charcot neuropathy would not affect blood vessels in the same way that it affects patients with diabetes who do not have Charcot neuropathy. Therefore, we should expect patients with Charcot to experience peripheral vascular disease at the same rate as patients with diabetes alone.

Perhaps the confusion centers around the fact that patients who suffer from Charcot neuropathy may present for care earlier in the course of their disease. As a result, we are potentially seeing patients with Charcot neuropathy and foot problems presenting years before patients with diabetes alone present for treatment. Regardless, we believe the incidence of PVD in patients with Charcot is high enough that one should perform a detailed vascular assessment prior to any surgery, especially if the patients present with non-healing wounds. Pre-surgical revascularization was necessary in 20 percent of our patients with Charcot neuroarthropathy. We also found vascular augmentation was necessary despite non-invasive studies in some cases not being consistent with critical limb ischemia, a finding Hafner and coworkers previously suggested.[10]

While this study had a limited number of patients, the findings suggest that PVD is still a concern for patients with Charcot deformities. We did see PVD evident in patients presenting within all stages of the Eichenholtz scale but further study is necessary to determine if there is any correlation to PVD. What is clear from the results of this study is that once one determines a patient has an abnormal bedside Doppler exam, at least 20 percent of patients may need revascularization and in the Stage III group, 50 percent required revascularization.

In Conclusion

With the well-known risk of PVD in patients with diabetes, one must perform routine vascular exams during normal evaluation. This study has shown a large percentage of patients with Charcot neuropathy and abnormal bedside Doppler have clinically significant vascular disease. Despite the common belief that patients with Charcot do not have blood flow problems, we believe that all patients with diabetes need thorough vascular evaluation, including those with Charcot neuropathy. In addition, revascularization may be necessary prior to any surgical intervention as others have previously advocated.11

We recommend conducting further studies to determine the true rate of PVD in patients with Charcot neuropathy. A nationwide Charcot database would be helpful in this regard.

Dr. Mancoll is in private practice at Mancoll Cosmetic and Plastic Surgery in Virginia Beach, Va.

Mr. Webb is a graduate of Norfolk State University and an incoming first-year student at the Barry University School of Podiatric Medicine.

Dr. Grant is a Fellow of the American College of Foot and Ankle Surgeons, and is board-certified by the American Board of Podiatric Surgery. He is an instructor in the Department of Surgery at Eastern Virginia Medical School and is in private practice in Virginia Beach, Va.

Presenter Discusses Common Foot, Ankle Injuries in Extreme Sports Athletes

BOULDER, Colo. — At the International Extreme Sports Medicine Congress, Kenneth Hunt, MD, discussed the three most common foot and ankle injuries in extreme sports athletes.

Hunt said he most often saw calcaneal fractures because patients have hard landings during sports.

"[Often]times, [we] repair them surgically and then we see a lot of midfoot injuries or Lisfranc injuries [that] can happen because of the impact to the foot, the ground or a pedal," he said.

He said most of these patients can get back to doing their desired activities once they heal.

Hunt noted that ligament injuries may result in acute or long-term issues, such as chronic instability. He said Physicians should identify factors that indicate whether a patient is able to return to sport or whether there is chronic instability which may require balance testing and outcome scores assessment.

"We always approach [ligament injuries] initially with the standard RICE therapy — rest, elevation, ice," Hunt said. "The majority of ligament injuries will get better with this technique. For those who do not get better, have significant instability or have associative lesions that will affect their outcomes, we will often have to take these patients to surgery."

Syndesmotic injuries or high ankle sprains are common ligament injuries that can be identified with fluoroscopic imaging. Hunt said there is movement toward the use of flexible fixation devices such as suture buttons rather than screws, as buttons do not stiffen the ankle.

"The syndesmosis is out of position 20% of the time with screws, and we haven't found a way to do that consistently intraoperatively; but with flexible fixation, there's almost never any malreduction because it basically puts [the syndesmosis] back where it wants to go," he said.

Achilles tendon ruptures take a long time to recover, around 9 to 12 months, according to Hunt. He said if orthopedic surgeons use the squeeze test, palpable gap test and the extensor lag test, they do not need to use MRI to identify these injuries. Achilles tendon ruptures can be treated either surgically or conservatively, although the trend is to treat athletes with surgery.

"Surgery is still the standard. There is a lower re-rupture rate, a higher rate of return to activity and work, and better strength and function. We are understanding this better and as surgical techniques are getting better, the risk of adverse events is getting lower," Hunt said. – *by Monica Jaramillo*

Reference:

Hunt K. Foot and ankle injuries – It's not only snowboarder ankle. Presented at: International Extreme Sports Medicine Congress; June 1-2, 2018; Boulder, Colorado.

Disclosures: Hunt reports he receives research support from Acumed LLC and Smith & Nephew; is a paid consultant for Panther Orthopaedics; is a board or committee member for the International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine and is a research committee member and is a board or committee member of the American Orthopaedic Foot and Ankle Society.

This year's Foot Health Month has been the most successful yet!

CFPM supported members with 1300 SIMCAN socks, 2000 postcards, 1000 journals and 300 posters!

May 2018 was an exciting month for foot health! We sold a record number of SIMCAN socks to members to assist in promotion of Foot Health Month.

CFPM members celebrated the month nationally and sent us some great news from their events.

Stephanie Playford

"Burlington Health Focus Foot Clinic had a very successful Foot Health Month this year! We started by having the Mayor of Burlington, Rick Goldring, officially proclaim May 2018 Foot Health Month in Burlington, ON. We followed that by sponsoring the Burlington Lawn Bowling Club for their opening jitney where I threw out the first bowl to start their season and gave 20 pairs of Simcan socks as prizes for draw winners. We finished our Foot Health Month campaign by running a very successful and inaugural annual Foot Health Month 5k walk/run with 76 registered participants!"

-Stephanie Playford, D. Ch, Burlington Health Focus Foot Clinic

Congratulations to Stephanie Playford and her team for executing great events!

Secrets of Success: Patient "no-shows"

(reprinted from 2010)

by Lynn Homisak

"What happened to Mrs. Baker today?" asks the doctor. "She had a two o'clock appointment and didn't show up."

Patient no shows...a daily scheduling occurrence that is more common than any of us would care to admit. Why do they happen? What do we do about them? And finally....how can we prevent them?

Let's start with "why?" The reason for no shows from a patient perspective could revolve around many things. Of course the possibility exists that their absence *could* have been the result of an unavoidable last minute conflict or an unfortunate mishap...and in those particularly rare cases, you find it easy to empathize. More likely, however, one of the following occurred...they were too busy, they forgot, didn't feel it was a priority, or just didn't understand the value of going. Then there are those who make a habit out of not showing and you can predict two weeks out, (thanks to the roadmap of red markings in their charts), exactly who they will be. What do we do about these patients?

By intentionally disregarding their actions, we are irresponsibly allowing these patients to diminish the value of our time. Except for those offices who have a rigid policy when dealing with patients who don't show (e.g. charging a fee or inconveniently re-scheduling them), there is, often times, little to no consequence to a patient who fails to show for this appointment or the last one...or the one before that....or the one, well, you get the picture. Sometimes without our realizing it, we allow our patients to sit in the driver's seat of our practice, instead of taking control of the wheel ourselves and the only way to avoid unwanted future wrecks is to realize that we need to reposition ourselves.

So how do we do that? First, by attaching value to our time and once we do, make the patient aware that we do. Unfortunately, some patients who have been told by the doctor to reschedule a follow-up appointment do so without fully understanding the reason why. Without proper doctor-patient communication, the patient is at a loss to associate any "value" to the appointment, and so if they happen to *miss* it, it is of no real significance. It is up to each one in the office - beginning with the doctor - to impress upon the patient that a follow up appointment is suggested for THEIR benefit, not ours. If the patient fails to appreciate that by the time they leave the office, there is a hole in the protocol/system somewhere that needs to be fixed.

It is important for the receptionist to be proactive when making the patient's follow up appointment. Again, reinforce the importance. Next, emphasize to the patient the courtesy of a call if he/she cannot keep the appointment and then also explain to them that their failure to keep the appointment scheduled for them could severely limit their chances for rescheduling at a convenient time. The strategy in this case should be, *"Mrs. Baker, if you cannot keep this appointment, we would appreciate the courtesy of a call to us so that we can then make it available to someone else who's been waiting to get in. We realize your time is important and should the situation ever arise where YOU would need to be seen, we would like to be able to offer you the same consideration."*

Remember, when we speak in terms of appointments to the patient, they only translate that into "increments of time." 15 minutes, 30 minutes, 45 minutes... they are merely time slots in your book to them. So, in addition to conveying the message that our time is valuable, we need to take the extra step to prove it and make them believe it. Think for a minute of the mixed message we send when scheduling two or more appointments in the same time period. (And don't be so naïve to think that they don't compare appointment notes while they are sitting in your reception room!) You cannot expect a patient to understand the value of that appointment knowing that you double booked them with someone else and forcing them to wait 40 minutes (or more)! Maybe the next time they are scheduled, they'll think it is "no big deal" if they don't show, with the notion that you already have someone else penned in to fill that "valuable" time slot anyway!

And so, we come to our final question....what can we do to prevent them? Without starting a debate on the pros and cons of calling patients to remind them of their scheduled appointment, I can only tell you that if you do (call), from a patient's perspective, you continue to live your philosophy by example...showing them that you assign importance to the time you have set aside for them.

In addition, calling your patients to confirm a day or so prior to their appointment allows for two very important things to occur:

1. You can verify your schedule for the next day;
2. You have an opportunity to fill newly vacant appointments with other patients who may be waiting for an opening.

Make your call count! Inform your patient that you will call to remind them of their appointment and be sure to ask where they can best be reached. Rather than just leaving a message on their machine, you want to call them at a place where you are sure to make a live connection. Some prefer home or cellphone, while others, their office phone or email. It can be argued that there are *still* the occasional no-shows even with a reminder call, but the truth is there are far less than without it. However you choose to deal with those patients who repetitively cancel, change or break their appointments, it's important to first follow up with a phone call for completeness of care. Document your call, their response and reason for not showing, and their rescheduled date (if they choose to make one). At every available opportunity stress the value of the time you are setting aside for them. It's up to you to teach them. If you don't...who will?

Ms. Homisak, President of SOS Healthcare Management Solutions, has a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management's Lifetime Achievement Award and recently inducted into the PM Hall of Fame. She has also recently been named as an Editorial Advisor for Podiatry Management Magazine and is recognized nationwide as a speaker, writer and expert in staff and human resource management.

www.soshms.com

Classified Ads

Chiropodist Needed to Take Over Existing Practice, Full-time or Part-time Whitby, ON

Our location is in a medically oriented mall in Whitby with plenty of free parking. Currently we have a Walk-in/Urgent Care clinic, 8 family physicians, Orthopedic surgeon, OBGYN's, pediatricians, paramedical offices as well as labs, pharmacy and imaging available on-site. Our office is roughly 3000sq/ft and you'd be joining a team of 4 physiotherapists, 2 chiropractors, 2 RMT's as well as assistants in a busy, well established office. You will have access to assistants as needed as well as 6 Ultrasound machines, two lasers, two shockwave and a BioFlex laser. We are also between a Service Canada and Service Ontario and enjoy a large flow of traffic. Our current Chiropodist sees roughly 7-10 new patients a week with no marketing effort. Our current Chiropodist is leaving so you will need to take over the existing clientele. Our office can offer 1-2 plumed rooms, 1 Chiropody chair, an autoclave, drill as well as an ultrasonic sonic sterilizer.

Requirements include;

- Ability to communicate effectively with both patients and Physicians in the building.
- Licensed by COCOO and have your own liability insurance or be eligible for insurance.
- Ability to work as part of a health care team as well as an individual.
- Ability to work within the entire Chiropodists Scope of Practice including but not limited to;
- Diagnose conditions and communicate the information needed to the patient.
- Be able to perform biomechanical exams and gait analysis.
- Perform injections including local Anesthetic and Cortisone.

Please contact wmauchdc@hotmail.com

Ashburnham Foot and Ankle Centre Peterborough, Ontario

Large progressive practice seeking business minded chiropodist/podiatrist for initial 12 month maternity leave commencing September 2018. The successful candidate will also have the option to explore ownership options including purchasing shares within the practice's corporate structure as part of a longer term commitment to the practice and the current ownership's goal of retirement. Situated in Peterborough, Ontario in the beautiful Kawartha Lakes region, it provides a unique opportunity for cottage lifestyle but close enough to major centres including Toronto, Ottawa and Kingston.
Contact Peter & Kathryn Ferguson at:
pkferguson2181@gmail.com
Or phone Peter Ferguson at 705 875-6053

Looking to start your own practice?

Rather than start from scratch why not consider buying an existing practice and start making money right away.

Practice for Sale Cambridge, ON

- Turn key operation
- All equipment and furnishings included.
- Good patient base (3000 plus) with room for growth. (Add surgery)
- Orthotic based practice
- 25 years of serving Cambridge full time (Monday to Friday).
- Lease expires in June 2019. Can be transferred or renegotiated.

I'm looking to retire but, will stay on to facilitate a smooth transition. Average annual gross over past 5 years $285,000 asking price $195,000 with vendor financing available.
Contact achillesfc@live.com

CFPM CALL FOR SUBMISSIONS

Are you interested in featuring your article in the Podiatrist? This is your chance, submit your work to **journal@cfpm.ca** for a chance to have it featured in the Spring 2019 issue

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CFPM Glove Program

> "I have been extremely impressed with priMED's nitrile examination gloves. Nitrile gloves offer enhanced tactile feel and is a wonderful alternative to latex with no allergic reaction. Wearing gloves is now effortless and comfortable."
> Stephen Hartman.

The CFPM has partnered with **priMED** to bring our members a new and exciting membership benefit. This program will provide CFPM members with preferred rates on both vinyl and nitrile examination gloves from priMED.

Vinyl and latex gloves have traditionally been the gloves of choice for podiatrists and chiropodists. Nitrile is a product new to the podiatry market and has the fit and comfort of latex without the allergic reaction. Nitrile meets and exceeds all Canadian Health Standards for medical examination gloves and is extremely resistant to punctures and tears. Visit www.podiatryinfocanada.ca to view a comparison of vinyl and nitrile examination gloves. Go to Membership > Glove Program to see the PDF.

priMED is a Canadian owned and operated corporation with a wholly owned manufacturing facility. priMED is a leader in the Canadian Health Care Market and has always prided themself on the fact that it is an engaged and responsive company that is committed to bringing high quality products to their partners and customers in Canada and abroad. Their deep product knowledge combined with their experience is a competitive advantage few can match.

The Order Form can also be found at CFPM's website, www.podiatryinfocanada.ca

Upcoming Events

2018

Oct. 5-7, 2018
New Mexico Podiatric Association Balloon Fiesta Conference
Albuquerque,NMa
www.apma.org

Oct. 10-14, 2018
GEF Annual Meeting & Kaplan-Clarke-Foster Golf Tournament
Pinehurst, NC
www.apma.org

Oct. 13-20, 2018
International Foot Ankle & Ankle Association
27th Annual Hawaii/Big Island Seminar
Hawaii
www.internationalfootankle.org

Oct. 18-20, 2018
Superbones Superwounds West
Las Vegas, NV
www.podiatry.com

Nov. 7-10, 2018
Desert Foot Conference
Phoenix, AZ
www.desertfoot.org

Nov. 8-10, 2018
CFPM 19th Annual Conference
Niagara Falls, ON
www.podiatryinfocanada.ca

Nov. 8-10, 2018
AAPPM Fall Conference
Anaheim, CA
www.aappm.org

Nov. 22-23, 2018
Society of Chiropodists and Podiatrists
Bournemouth, UK
www.scpod.org/conference

2019

Jan. 15-24, 2019
International Foot & Ankle Foundation
Azamara Journey Ship
Cuba
www.internationalfootankle.org

Jan. 26-27, 2019
Present Podiatry Treasure Hunt
Los Angeles, CA
www.podiatry.com

Feb. 7-9, 2019
32nd Annual Lake Tahoe Ski Seminar
South Lake Tahoe, CA
www.internationalfootankle.org

April 5-7, 2019
Superbones Superwounds East
Teaneck, NJ
www.podiatry.com

May 16-18, 2019
AAPPM Spring Conference
Baltimore, MB
www.aappm.org

June 27-29, 2019
41st Seattle Summer Seminar
Seattle, WA
www.internationalfootankle.org

July 11-14, 2019
The National
Salt Lake City, UT
www.apma.org

Aug. 11-17, 2019
International Association for Identification
Reno, NV
www.theiai.org

Aug. 14-24, 2019
Lisbon and Enticing Duoro River Cruise
Lisbon, Portugal
www.internationalfootankle.org

Oct. 31-Nov. 2, 2019
World Congress of Podiatry
Cancun, Mexico
www.podiatry2019.org

Nov. 7-9, 2019
AAPPM Fall Conference
Daytona Beach, FL
www.aappm.org

Nov. 14-16, 2019
FIP World Congress of Podiatry
Miami, FL
www.podiatry2019.org

2020

July 23-26, 2020
The National
Boston, MA
www.apma.org

Aug. 9-15, 2020
International Association for Identification
Orlando, FL
www.theiai.org

2021

July 22-25, 2021
The National
Orlando, FL
www.apma.org

Aug. 1-7, 2021
International Association for Identification
Nashville, TN
www.theiai.org

2022

International Association for Identification
Omaha, NE
www.theiai.org

2023

International Association for Identification
Harbor, MD
www.theiai.org

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