Volume 13 • Number 2 • **FALL 2019**

the Canadian PODIATRIST

The official publication of the Canadian Federation of Podiatric Medicine

Ontario Chiropodists Volunteer FOR SPECIAL OLYMPICS

Fit Feet Program **PG.08**

FEET FIRST:

Instrumented Insoles to Examine Workplace Injury Risk **PG.18**

plus

CONFERENCE UPDATES!

PG.27

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IN THIS ISSUE...

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FROM THE **PRESIDENT**

Welcome to the Fall 2019 issue of The Canadian Podiatrist. My name is Stephanie Playford and I'm the current president of the CFPM. First and foremost, however, I'm the very proud mom of 16-year-old twins, Matthew and Breanna. Those of you who are also parents of teenagers will I'm sure agree that it is an exciting stage. I fear I will never have my car again.

I was born and raised in the beautiful city of Owen Sound, Ontario and as many of my family still live there, I'm glad to be able to still enjoy time there.

I graduated from the Michener Institute for Applied Health Sciences Chiropody program in 1995 and after working for a time in the Chiropody department at Laurentian Hospital in Sudbury I moved to Burlington, Ontario where, in January of 1997, I opened my private practice. I'm happy to say that I have been in private practice there ever since.

Baby Rees

I have been a proud member of the CFPM since its inception in 1999 and have served on the board now for several years. I was honoured to take over the position of President from Dr. Helen Rees after the birth of her first child earlier this year. She tells me her new son is a wonderful baby with a brilliant smiley personality who's adventurous like his mother. Congratulations Helen!

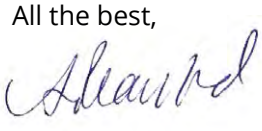
Speaking of adventure, we have some exciting things happening in this upcoming year, including our Annual conference being held in Mississauga. The conference is our Marquee event, with a full roster of international speakers across all corners of Podiatry, as well as networking events, courses for CPR training and Podiatric assistants, and more!

Education in CFPM isn't limited to the conference. You'll find two interesting case studies in this issue, starting with Instrumental Insoles to Examine Workplace Injury Risk (page 18), something all our busy feet could benefit from keeping front of mind. We then have an interesting look at podiatric lesions and dermatology with Inflammatory Linear Verrucous Epidermal Naevus – Whose Line is it Anyway (page 11).

Complementing the science that defines our profession is the science of practice management, and you'll find written pieces such as Secrets of Success: Do you Play Favourites? (page 15) for HR insights.

As always, if you have any thoughts, questions, or feedback that you would like to share don't hesitate to contact me at president@cfpmcanada.ca

All the best,



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FROM THE **EXECUTIVE** DIRECTOR

I recently visited with a few of my good friends in my adopted home province of Nova Scotia. The combination of sun, sky and ocean on a beautiful late summer day can have an intoxicating effect on your mood and your spirit. In my opinion, it is one of the best places on earth.

During my stay, an old friend was embarking upon a 300 kilometre fundraising walk around the Cabot Trail on Cape Breton Island. Having completed the 780 km distance of the Camino de Santiago earlier in the year, my friend was well-prepared for the journey and the challenge. And despite the steep mountains in the Nova Scotia Highlands, he paced himself well as he completed the walk in under 10 days. Not bad for a 68 year old.

Long distance walking can be a spiritual experience. It also brings with it small (and impactful) inconveniences such as callouses, blisters and lost toenails. Camino pilgrims, especially the seasoned ones, will often share their traditional and not so traditional foot care rituals and treatments that extend the life of their feet and allow them to make it to the next village. Ask any pilgrim; they will tell you the difference between starting and finishing the Camino is healthy feet.

Earlier this year I took over as Executive Director of CFPM. I have been an association executive for nearly 30 years and have owned Essentient Association Management for nearly fifteen years. Our company, while relatively small, is a leader in the association management company space. I am the current President of the AMC Institute Canadian Chapter and Immediate Past President of the Canadian Society of Association Executives Trillium Chapter and I am also a Certified Association Executive (CAE), my profession's highest achievement.

My staff and I are learning as much as we can about Podiatry, the profession and the regulatory environment in which you all work. It's a lot to take in but we manage it day by day. Our understanding of the integral role that podiatry plays in healthcare has given us a newfound respect for foot care professionals.

We are also hard at work organizing CFPM's 20th Annual Conference this November. As you know, Stephen Hartman has been at the helm of this successful event for nearly two decades. I would like to personally thank him for showing us the ropes and lending his guidance and insights.

And finally, I am grateful to Stephanie Playford, CFPM President, for her leadership and her professionalism. We have many challenges as an association and as a profession, but Stephanie sees the opportunities that will enable us to go the distance.

I hope to meet you at the 20th Annual Conference at the Hilton Meadowvale Hotel, November 7 to 9, 2019.

Constance Wrigley-Thomas, CAE
Executive Director – CFPM
constance@cfpmcanada.ca

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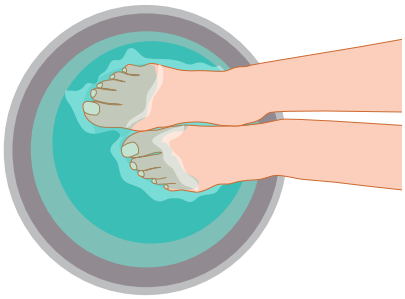

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Special Olympics Fit Feet

Olga Lalande (Clinical Director for Fit Feet Ontario) with a Barrie high school soccer team at the National School Championships in Peterborough 2018.

What is the Healthy Athletes Program?

Healthy Athletes is a Special Olympics program that provides free health screenings in a fun, welcoming environment that removes the anxiety and trepidation people with developmental disabilities often experience when faced with a visit to a healthcare provider.

The Fit Feet screening program is the newest addition to the Special Olympics Healthy Athlete program started in the United States in 1991. The mission of the Fit Feet program is to improve the quality of life and long-term health of Special Olympic athletes and people with developmental disabilities. It also aims to raise awareness in the Chiropodist and Podiatrist community of the foot concerns of those with developmental disabilities and difficulties in accessing treatment.

These free screenings evaluate ankles, feet, lower extremity biomechanics, and footwear. Fit Feet screenings give athletes, coaches and caregivers a better understanding of any existing and previously unknown foot problems. A list of regional Practitioners is also provided to help facilitate follow through in care. The data collected through these screenings help to advocate for better health care for all individuals with developmental disabilities.

Chiropodist volunteers performing a Fit Feet Screening in Kingston, January 2019

During these screenings the data has shown that a large percentage of Special Olympic athletes have untreated foot conditions and poor footwear:

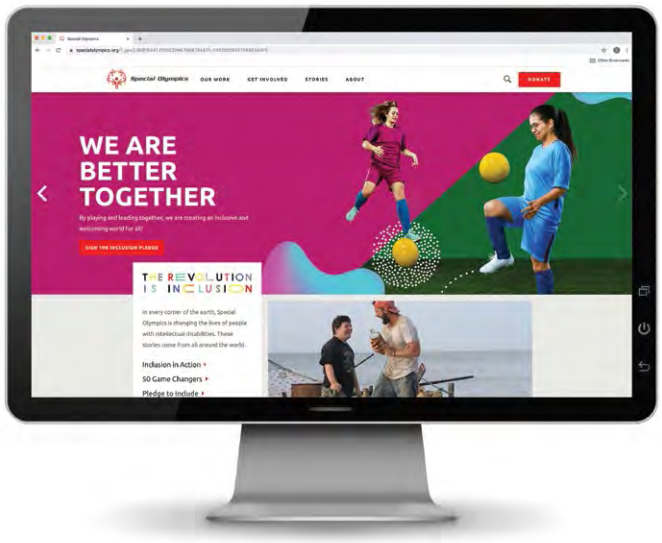
50% have gait abnormalities

53% have skin and nail conditions

21% have bone deformities

41% are wearing inappropriate or wrong size footwear

Fit Feet would not be possible without the dedicated group of Chiropodist Volunteers who give their time and expertise to help better the lives of these athletes and all of those with developmental disabilities!



To learn more about
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https://resources.specialolympics.org/health/fit-feet

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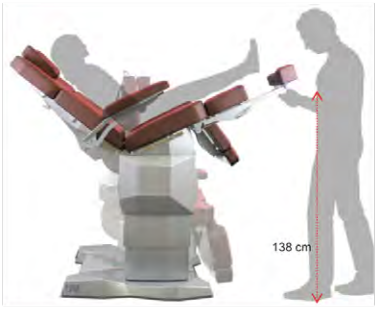

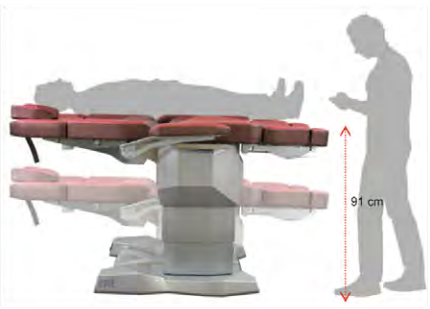

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INFLAMMATORY LINEAR VERRUCOUS EPIDERMAL NAEVUS – Whose line is it anyway?

Dermatology and the manifestation of skin disease can show great diversity. The authors present an unusual podiatric lesion demonstrating a well-recognised, but rarely discussed, dermatological pattern.

Ivan Bristow PhD, Podiatrist, Hampshire, UK
Georgie Evans BSc (Hons), Podiatrist, Saskatchewan, Canada

Case Presentation

A mother presented her three-year-old son to the podiatry clinic with a developing skin lesion on his leg and foot. The child was 36 months old and in good health apart from asthma for which an inhaler was used. Previously he had had pneumonia but his development from birth was otherwise good as he had attained all the normal milestones. The pregnancy was normal, but the mother had developed gestational diabetes during the term. He was born three weeks premature without complications.

On examination, he presented with a linear lesion (about 1cm in diameter) running from his groin, along the medial side of his left leg to the plantar surface of the calcaneum (figures 1 - 3). The lesion was initially papular in structure but evolved, merging to form a discontinuous plaque. It had gradually developed from two months after birth and was roughened in texture and extremely pruritic. No other skin lesions were evident on the patient. Rubbing from diapers had previously caused bleeding but since toilet training this was no longer an issue. The initial diagnosis was made by the patient's general practitioner as lichen planus for which he was prescribed salicylic acid. This was uncomfortable and increased the soreness and so he was subsequently prescribed a moderately potent steroid. This reduced the itching, but the lesion remained.

Diagnosis: Inflammatory Linear Verrucous Epidermal Naevus (ILVEN)

A naevus is defined as an abnormal collection of normal skin cells which most often is present at birth. An epidermal naevus, denotes a lesion composed of primarily keratinocytes. The verrucous epidermal naevus is a rare sub-type (around 1:1000 children) which affects males and females equally and mostly arises just after birth within a few months. It develops initially as velvety linear streaks that become warty with an erythemic base as the lesion evolves. Lesions are most frequently observed on the limbs[1] (particularly the left leg[2], occasionally on the trunk but rarely on the mucosal or genital areas[3]. The length of the naevus is highly variable from very short to the entire length of a limb. In such cases, nail involvement can arise and present as hyperkeratosis and inflammation[4].

ILVEN can be eczematous or psoriatic in form with flexural lesions that can become macerated. For most, ILVEN presents as a single line although bilateral cases do arise. It can be classified as non-epidermolytic and epidermolytic in form. The former is the most common and is usually restricted to the skin but the epidermolytic form is associated with extra-cutaneous features. Around one-third of patients are suspected to have involvement beyond the cutaneous manifestations including the mucosal surfaces, dentition[5], the central nervous system[6] and skeleton[7]. No evidence of extra-cutaneous involvement was apparent in our patient suggesting a non-epidermolytic form of the condition.


Figure 1


Figure 2


Figure 3

Differential Diagnosis

The clinical picture can give strong clues as to the cause, but biopsy can be helpful in confirming the diagnosis. The main differential diagnosis is with lichen striatus (LS). This being a similar presenting condition in children. It begins with pink or red papules in a linear arrangement along the limb. It can be singular or in parallel lines. In contrast to ILVEN, affected children are older (5-15 years of age). Moreover, the lesions associated with LS are generally asymptomatic and resolve on their own within months regardless of treatment[8].

Management of ILVEN

Once established the condition remains static but symptoms of itching can persist and may require topical therapies. Corticosteroids have also been used topically but with limited success. In addition, various papers have reported the use of retinoids, 5-fluorouracil and dithranol[3,9]. Two papers have reported the successful use of calcipotriol in children with the disorder[10, 11]. Laser ablation has also shown improvement in symptoms and appearance in treated lesions[4, 12].

Why the distinct linear pattern in these diseases?

Podiatrists may be familiar with various anatomical lines in the body including Langer lines, dermatomes, the soleal line and even Wallace's line of the foot[13] but dermatologically, some inherited and acquired disorders can develop along another set of lines - the lines of Blaschko. In 1901, Alfred Blaschko[14] first described a set of invisible lines occurring in the skin that did not conform to any known anatomical pathway such as nerves, blood vessels, or lymphatics, but were sometimes demonstrated by the presence of certain skin diseases and naevi. It is now thought these lines represent epidermal cell migration and proliferation pathways from development of the foetus. Blaschko's lines run their unique course of whorls, lines, and wave-like shapes across skin and mucosal surfaces. The pattern of the lines can be seen in figure 4. In the lower limbs these tend to be represented by vertical straight lines.

Blaschko's lines are regarded as a manifestation of mosaicism. A mosaic is considered an artwork which is made of multiple, small coloured pieces of stone or glass. In genetics, a mosaic refers to an individual made up of two genetically distinct cell populations that are derived from a homozygous zygote[15].

Mosaicism, or separate cell populations, can develop in two ways. Firstly, by spontaneous mutation in the DNA sequence so that subsequent daughter cells contain the genetically distinct material. Secondly, it can result from changes in gene expression that are passed on from one cell generation to the next but do not entail an alteration in the DNA sequence – known as epigenetic factors[15]. The stage at which the change occurred determines the extent of the phenotypic expression. If the mutation occurred early in embryonic development, the abnormal cells will likely be widely distributed and affect multiple tissues, whereas a mutation that occurred late in development will be limited in distribution and might affect only the skin, for example.

During embryological development, epidermal tissue develops in streams. If one imagines coffee and milk as the two distinct cell lines, pouring milk into coffee causes a swirling mixture that creates the observed mosaic pattern (figure 5) akin to the appearance seen on the skin. A similar phenomenon is seen in animals, such as the brindle colouration of dogs (figure 6) being analogous to the lines of Blaschko in humans[16].

Mosaicism can occur in any tissue or organ and is rarely visualised and in human skin they can only be seen under intense UV light or as the manifestation of the pattern of certain skin diseases which follow the lines of Blaschko. There are several skin disorders which follow the lines of Blaschko (table 1) including a rare form of linear psoriasis and lichen planus. Subsequent research has established four other cutaneous patterns that may manifest during skin disease and may also represent mosaicism[17], which are less frequently observed.

Suggested Reading: Blaschko's Lines

(www.dermnetnz.org/topics/blaschko-lines/)

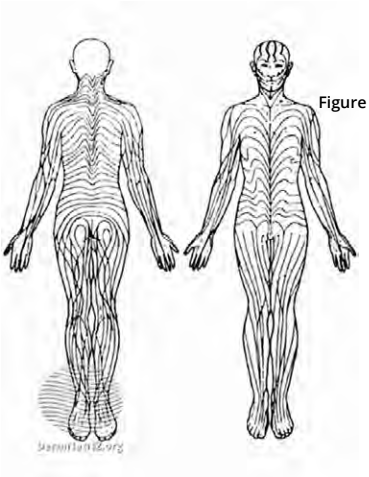

Figure 4

Figure 5

Figure 6

CONGENITAL SKIN DISORDERS	
X-linked dominant skin disorders	Incontinentia pigmenti Focal dermal hypoplasia CHILD syndrome MLS syndrome Oral facial digital syndrome Type 1 X- linked dominant chondroplasia punctate
Epithelial naevi	Inflammatory linear verrucous epidermal naevus Sebaceous naevus Non-organoid epidermal naevus
Pigmentary disorders	Pigmentary demarcation lines Naevus achromicus (including hypomelanosis of Ito) McCune–Albright syndrome Segmental vitiligo
ACQUIRED SKIN DISORDERS	
Disorders with polygenic background	Linear lichen planus Linear psoriasis Linear cutaneous lupus erythematosus Lichen striatus Linear morphoea

Table 1. Skin conditions that are known to follow Blaschko's lines[18]

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Figure 1: Medical view of the thigh
Figure 2: Medical view of the calf
Figure 3: Plantar view of the calcaneum
Figure 4: Map of Blaschko's lines. [Note to editor creative commons licence]
Figure 5: Visual depiction of cell streaming during embryonic development with two distinct cell lines (coffee v. milk). [Note to editor creative commons licence]
Figure 6: A dog with brindle colouration – a canine equivalent of the lines of Blaschko. [Note to editor creative commons licence]

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SECRETS OF SUCCESS: DO YOU PLAY Favourites?

By Lynn Homisak

Do you play favourites? How can I answer that without any sugarcoating? DON'T! If you cater to one or more employees over others, it confirms you are intentionally exhibiting some form of neglect and harassment. It may seem very innocent and reasonable to give more attention and offer greater leeway to a staffer you perceive as more reliable and ambitious. However, this favouritism, no matter how minor, is the fuse to a practice time bomb! It can cause low morale, costly staff turnover, loss of good staff, resentment, retaliation, reduced productivity, poor management practices, and lack of teamwork. Boom! I won't mention lawsuit.

You have a responsibility to treat employees fairly and equally across the board. This could apply to a number of incidents. Look in your employee manual – I'm sure the equality/discrimination rules are clearly defined and if disregarded, will certainly come with consequences. If you have issues with underperforming staff, have that discussion with them through evaluations and reviews, opportunities for improvement, and disciplinary write ups. If their level of performance does not improve after guidance and counselling, then take the necessary termination steps.

The following is a short list of common, blatant favouritism behaviors. There is no excuse for any one of them. Use it as a self-assessment test and be honest with yourself.

Do you...	Yes	No
Reprimand some staff for coming in late, but turn a blind eye to others?		
Extend extra perks to only one employee, even though the performance of others is equally deserving?		
Offer continuous high verbal praise and appreciation to a few and ignore the accomplishments of their co-workers?		
Admonish a select few for small errors or carelessness, while larger errors by favourite employees are overlooked?		
Make excuses for some, but not others?		
Look only to certain people for their ideas and opinions?		
Demonstrate physical affection (smiles, laughing, arm touching, etc.) to select staff?		
Show an obvious bias to work performed by one or a select few individuals?		
Give preferential treatment to a friend, relative or romantic partner employed by the practice?		
Often choose one employee (in a non-management position) to be in charge without considering other co-workers?		
Insist that preferred staff care for the more likeable patients and assign less desirable ones to others?		
Deny the request for more hours to some staff, while offering them to others with similar job responsibilities?		
Do favours for some and not others?		

If you have had a role in any of the above, intentional or not, insisting it's all in jest, take the necessary steps to rectify things right now.

- Treat everyone *equally.*
- Be aware of your behaviours and actions – innocent as they may seem.
- Follow written employee policy and office rules and apply them across the board, *equally.*
- Conduct performance reviews and base wage increases, perks, etc. on levels of actual performance.
- Assign duties based on skills, abilities, and job descriptions.
- Enjoy your workplace, with everyone, equally.
- Communicate.

If you believe this is overreaction, brace yourself. It's just a matter of time before even the slightest discrimination will cause a backlash that will play out as an internal disruption or a legal repercussion. I am a huge proponent of joy in the workplace. Have fun. Did I mention treat everyone equally?

Lynn 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. Lynn is also an Editorial Advisor for Podiatry Management Magazine and recognized nationwide as a speaker, writer and expert in staff and human resource management.

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OBJECTIVES OF PROGRAM AND TARGET AUDIENCE

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- Registrant must be an assistant member of CFPM and actively employed by a Chiropodist or Podiatrist member of CFPM
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- To be eligible to write the exam, the student must have worked as a podiatric assistant for a minimum of one year
- Must have current First Aid and CPR certification

PRE-REQUISITE BOOK

Memmler's Structure and Function of the Human Body, 10th edition. By Taylor, Jason J. & Cohen, Barbara J. Baltimore: Lippincott Williams & Wilkens, 2013.

RECOMMENDED BOOKS

- Common Foot Disorders by Neale, Donald & Adams, Isobel. Churchill & Livingstone
- Saunders Medical Office Management, 3rd edition. By Alice A Andress

TIMELINE TO COMPLETE

2+ months (must write exam at conference within 23 months of registering for program). At the end of each chapter are questions to be completed. Please have your employer or colleague mark your chapter questions and record the completion date and grade. This information will be required to be handed into CFPM at the time of the final exam.

RECOMMENDED ADJUNCT WORKSHOPS

- Hands on training or workshops are recommended to be completed at conferences prior to writing the final exam
- Passing grade on final exam, examination date for first intake of registrants is at the CFPM conference in November 2019
- Must attain a minimum of 80% to pass

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FEET FIRST: INSTRUMENTED INSOLES TO EXAMINE WORKPLACE INJURY RISK

Michael Ryan[1,2], Evan McDonald[3], Carolyn Sparrey[3]

[1]Kiwi Orthotic Services, Surrey, BC
[2]Department of Biomedical Physiology and Kinesiology, Simon Fraser University, Burnaby, BC
[3]School of Mechatronics Systems Engineering, Simon Fraser University, Burnaby, BC

PURPOSE:

Plantar fasciitis (PF) is a condition that causes foot pain and sometimes even prevents people from walking. Each year, approximately 2.77 million people in the United States report having PF[5]. This costs over $284 USD million per year[6]. The exact cause of PF is unknown. Research has shown that standing for long periods of time can increase the risk of getting foot pain[7].

Researchers often ask participants to self-report the amount of time spent standing during the workday. This can lead to large errors, as shown in one study where participants incorrectly reported over 3 hours of activity time over a 24-hour period[3].

Current technologies used to track activities are either too expensive or too difficult to use. Without improvements in this technology, it is difficult to develop links between foot pain and specific workplace activities. This is where the Posture Differentiating Insole (PDI) can contribute. The PDI is a prototype smart insole developed by our team at Simon Fraser University. The PDI can evaluate whether a person is sitting, standing or walking at any point during their workday. In this study we have used the PDI to begin to assess the cause of foot pain at work.

RESEARCH QUESTION:

1. How does the PDI perform in a workplace for extended duration activity tracking?
2. How do self-reported activity durations compare to the actual activity durations recorded by the PDI?
3. Is there a relation between the amount of foot pain experienced by a worker and the following factors?
   - **a.** Amount of time workers spend standing or walking during their workday
   - **b.** How many times workers switch activities throughout their workday
   - **c.** How long workers stand still before walking or sitting down

METHODS:

We asked healthy participants both with and without foot pain between the ages of 19 and 60 to participate in our study. A total of 34 participants wore The PDI at work for up to 5 days while they went about their normal workday activities. At the end of each day, participants were asked about their foot pain throughout the day. They were also asked to estimate how much time they spent sitting, standing and walking throughout that day.

During the study, each participant completed a 30-minute device calibration procedure. They were asked to sit, stand and walk for two minutes each in a specific order. Then they were asked to include several posture changes such as fidgeting, standing on one foot, and sitting with legs crossed. This was recorded on video so that researchers could tell exactly when the participant changed activities. This data was used to train the PDI to recognize sitting, standing and walking throughout the rest of the workday.

RESULTS:

This study showed that the PDI device can be used in a workplace environment for up to 12 hours per day and up to 5 days in a row. Participants reported that they typically forgot they were wearing the insoles. This means we were able to record the participants' natural activities while at work. The computer algorithm was able to correctly determine the participants' activity 97.7% of the time.

Sensors in some of the PDIs broke before the end of the study, but most of them worked for the entire study. Data from devices that did not work correctly was not included in the analysis. At completion of the data collection, 96 days of data from 29 participants was able to be analyzed.

The total amount of time each participant spent sitting, standing and walking each day was determined by the PDI. This data was compared to what was self-reported by each participant at the end of each day. We found that the self-reported data had an average classification error of 23%, meaning that participants incorrectly reported an average of 2.15 hours of their working day. Participants usually reported more walking, and less standing than they actually did throughout the day. Sitting was about even.

We looked at how 15 different factors are related to foot pain. We found that more time spent standing and walking throughout the workday is likely to increase the occurrence of foot pain. We were also able to time how long a participant stands before either walking or sitting down. This is something that cannot be measured with self-reported activity data. We found that a longer amount of time spent standing or walking before changing activities is also likely to increase the occurrence of foot pain.

APPLICATIONS:

This study has shown that the PDI can greatly improve on self-reported activity data and provide new accurate information on workplace activity. This study highlighted multiple factors that may increase the occurrence of foot pain. An important next step is to use the PDI in a study with a greater number of participants to further quantify the relationships that may exist between the factors that this study highlighted as being important. Researchers will be able to use this device to study other activity related conditions such as back pain where methods of measuring activity times have shown a need for improvement.

The results of this study show the inaccuracy of self-reported data. We recommend using caution when making decisions (policy or otherwise) based only on self-reported data. This is especially important when looking at self-reported activity data, as shown by this study.

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WOUND BED ASSESSMENT; SLOUGH VS PURULENCE

Dr. Axel Rohrmann, Podiatrist

I have found wound care to be both challenging and rewarding and have tried many products over time with varying degrees of success. What we do know is that wound tissues are constantly changing, and we need to keep on top of the changes as they happen for the best outcomes.

A thorough and accurate wound assessment is one of the initial steps in determining the plan of care. Wound assessment needs to be accurately documented to paint a picture of what is truly happening with the wound and using photos is your best documentation. Wound base and exudate management are often the most challenging factors to control in the wound care plan.

TISSUE TYPE: SLOUGH

We've all heard about slough... most of us have seen it, debrided it, and even watched it change from wet (stringy, moist, yellow) to dry eschar (thick, leathery, black). Slough is necrotic tissue that needs to be removed from the wound for healing to take place. When referring to slough, some terms may be used interchangeably – fibrotic tissue or necrotic tissue most commonly.
It is important to differentiate between wet necrotic tissue and dry necrotic tissue to formulate the best evidenced-based wound care treatment plan.

As wound care clinicians, when we see slough, we want to get rid of it so that the wound is able to heal because necrotic tissue prevents or slows healing. So we refer to our wound care "tool box" and develop the best plan of attack:

- Sharp debridement either chairside or in operating room
- Autolytic debridement
- Chemical or enzymatic debridement
- Mechanical debridement
- Biologic debridement

Once we initiate our wound care plan (usually from the choices listed above), debridement will begin. As debridement occurs, the slough liquefies or dissolves and is (sometimes slowly) removed from the wound bed. However, as slough liquefies, the drainage may be confused with purulent drainage, depending on the clinician's assessment and experience. Additionally,

> when referring to slough,
> some terms may be used interchangeably –
> fibrotic tissue or necrotic tissue most commonly

as we know, wound drainage has an odour most of the time. That is why we do not document odour until after we have removed the old dressing, disposed of it, and cleansed the wound. If there is still an odour after completing those steps, then it is appropriate to document malodor as present.

PURULENCE AND INFECTION

So, is the drainage liquefied slough or truly purulence? Purulence–which means the presence of pus–and infection may go hand in hand in a wound...so, what are the signs and symptoms of infection?

- Erythema
- Odour
- Pain
- Redness that does not improve with elevation in a limb (not dependent rubor)
- Increase in drainage (color: green/blue, etc.)
- Elevated skin temperature (more than 6 degrees suspect bone involvement)
- Fever, chills, nausea, vomiting (systemic)

Does your patient have signs or symptoms of infection, along with purulence? Or are you simply wiping away the slough that has liquefied as the debriding agent does its job? Remember to look at the big picture, examine the peri-wound, compare assessments and documentation from past to present, and ask for someone else to lay eyes on your assessment if you're questioning it or take a swab and send for MC&S

Some additional tips for when you're not sure:

- Always cleanse the wound before documenting odour.
- If you're not sure what it is, don't document it yet – check first (keep in mind slough can be confused with purulence, tendon, or other underlying structures).
- If something doesn't look right to you, it probably isn't – trust yourself and notify appropriate team members.
- If what you're cleansing out of the wound is stringy and yellow, and the wound base appears more granular after cleansing, it is most likely slough.
- If there is an odour, erythema, and signs and symptoms of infection, you're most likely dealing with purulence or purulent drainage.

ADDITIONAL IMPORTANT TAKEAWAY POINTS

- Anytime you have a stable eschar on a heel (no fluctuance, purulence, odour, etc.), do not unroof or debride it. Keep it dry and stable, offload the area as much as possible, and only start the debridement process when the necrotic eschar starts to break down. If vascularity is adequate for wound healing then start with aggressive debridement.
- You will not see slough in a stage 2 pressure injury. Slough is present only in stage 3 pressure injuries and higher, though any wound can become sloughy.
- Biofilms may be present, especially in chronic wounds, but they are usually not visible to the naked eye and can be confused with onset of collagen base in the chronic wound.

A wound typically cannot heal if either infection or slough is present, but the treatment plan for each is very different. Being thorough and taking a multidisciplinary approach to managing the entire patient are critical to wound healing.

HOW TO TAKE CONTROL OF YOUR ONLINE REPUTATION

When it comes to managing your reputation and generating patient reviews, your practice has two options. You can one, execute a program to drive positive reviews with the help of an experienced online marketing expert. Or two, you can ignore your reviews. The latter will result in little to no exposure for your practice on the search engines and limited control over your reputation.

To start monitoring and managing your online reputation, your practice should first establish an online presence through a professional, interactive website. You also need to optimize your site for local search, which involves implementing an aggressive search engine optimization plan, claiming your local Google Place Page, submitting your website to local search directories and acquiring positive reviews from your most loyal and satisfied patients.

Taking a more proactive approach to participating in, monitoring and controlling online reviews is one of the best ways podiatrists can influence new patient leads and ultimately the appointment decision. Make the process for patients to give a review easy with as few steps involved as possible. Focus on your loyal patients who have been continuously satisfied with your services and quality of care. These patients already trust your ability to deliver and provide experienced foot and ankle treatment and will be more willing to offer positive feedback for your practice. This may include handing patients a card as they leave your office with simple instructions about how to leave a review from your website.

> … a more proactive approach to participating in, monitoring and controlling online reviews is one of the best ways podiatrists can influence new patient leads …

Unfortunately, you don't have control over which reviews will display next to your listing, and despite your best efforts, you can't always avoid negative reviews from manifesting themselves among your positive reviews. Manage any undesirable comments by outnumbering the negative reviews with positive reviews. The more positive comments prospective patients read about your practice, the less influence any negative reviews will have on their decision-making process.

You'll also want to start engaging on popular social media sites, such as Facebook and Twitter if you want to create a buzz about your practice on the Web. Once your existing patients connect with your network, they can share your practice information with their own network of friends—true viral marketing. For instance, suppose a patient comes

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to your office for heel pain treatment and you prescribe orthotics for her discomfort. After leaving the office, the patient is so satisfied with the outcome of her visit that she posts a comment about your practice on her Facebook and Twitter pages, communicating her deep satisfaction and gratitude for your services. Within seconds her entire network has access to her review. Social media offers a tremendous opportunity for open, transparent communication with existing patients and honest reviews for potential patients.

> existing patients connect with your network, they can share your practice information with their own network of friends—true viral marketing

Online reviews are quickly becoming one of the most important and effective ways to reach potential patients searching for podiatrists in your neighborhood. Podiatrists without a local presence are missing out on qualified leads who have abandoned their phone books for online search engines. Partnered with an expert in website development and Internet marketing, a comprehensive practice website combined with an aggressive local search campaign and strong online reputation will ultimately result in more clicks and new patients in the form of website traffic, phone calls, e-mails and office visits.

Building a successful web presence is easy when you team up with an expert in medical web design and online marketing. The CFPM and Officite have partnered together to offer professional website development and Internet marketing for Members at a discounted rate. Officite has built more than 5,000 websites that have generated over a quarter of a million appointment requests since 2002. As the number one digital marketing company for healthcare professionals, Officite offers premium designs, easy self-editing capabilities, search marketing and patient education—designed to educate and attract new patients while creating a prominent presence in the marketplace.
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