AAWP Newsletter

Serving Women Podiatrists Nationwide

Winter, 2003

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

AAWP President's Report

The Decision to Become a Mentor

By Marlene Reid, DPM

Why become a mentor for a young female student or new practioner? Six years ago, a student AAWP member from the Scholl College of Podiatric Medicine sent me a letter wondering if I was looking for help in the office. My partner and I really were not interested at that time, but we loved working with the residents and thought this would be a great way to help shape a future fellow colleague. Our experience with the many residents at our hospital and surgical centers that we have trained has shown us that the excitement and enthusiasm that we have for our profession can make as much of an influence on a resident as technical training. With all the negativism that exists within the world of podiatry, it is especially important residents and students are exposed to positive role models.

This young woman began to work in the office as a receptionist, assistant, x-ray tech, etc. At first the only difference between her training and that of any other office staff member was that she had a genuine interest in what she was doing and a commitment to understanding and excelling. As I expected, I quickly found that I spent much more time with this girl compared to other new staff members. I was treating her as a resident and was teaching more then training. She was learning things and doing things that she would not learn in school for at least another year.

As the next two years progressed, she came to learn anatomy and pathology and understand the rationale for surgical procedures. She was able to interpret radiographs clinically as opposed to memorization. She really learned how to examine a lower extremity as opposed to going through the motions. She mastered injections before her classmates even began to practice.

This mentoring required my time as well as my resources—she was hired to do the receptionist/back office stuff but in actuality, I needed to have someone else cover those responsibilities because she was busy playing doctor. I must admit there were days when I really did not want to spend the extra time required of me, but I got such satisfaction out of shaping, molding and influencing another individual. She often told me that I was such a strong influence on her as to what type of physician she wanted to be and that it was because of us that she had achieved her goals. When she went through the residency application process, it was evident that she had her choice of programs. She matched with her number one pick, a three year program.

Now, almost six years later, this student is preparing to join our practice. Since she was a student, she knew one day that she wanted to work side by side with us in our practice. Were we looking to hire an associate? Not really, but I know this young women well and she will make an excellent podiatric physician, diagnostician and surgeon and a wonderful asset to my practice!

Barry University Visits Ann Storck Center

Nicklya Harris, President, BUSGMS Chapter of AAWP

On a slightly cloudy but still jovial October 26 day, the ladies of the Barry chapter of AAWP presented the residents and staff of the Ann Storck's Rehabilitation Center with proceeds collected from a school wide drive, and also with an ice cream party.

The An Storck Center is a rehabilitory facility for mentally and physically challenged children and adults. Based out of Pembroke Pines, FL, the private facility is home to hundreds of residents, housed in three separate buildings on a huge, rural stretch of land. It has been so for 19 years. Pam Dawkins, the nursing director and contact for this occasion, has been with the facility for fourteen years.

The drive for toiletries and other personal items for the residents was begun more than two weeks prior by the club secretary, Leah Ford. Taking the lead for this October event, she placed boxes in the podiatry building at Barry. Students were asked to bring in personal items to be donated to the center.

Though held on a weekend proceeding many major tests, turn-out for the event was still very good, with over 1/3 of the club members participating. Around 35 residents and many staff members were brought into the main living area as the presentation of the drive proceeds were presented. Then members prepared bowls and cones of ice-cream, while others proceeded to actually feed the residents.

It was a very humbling experience, as well as fulfilling and fun. Not only did members participate in the party, but family of members as well. Junior Francisca Harrell brought her husband along to the event, and Freshman Elizabeth Londono brought her daughter Aby.

After the party, members were given a tour of the facility by Ms. Dawkins.

"The View" of BUSGMS

Nicklya Harris, President, BUSGMS Chapter, AAWP

On September 21, the Barry Chapter of AAWP hosted the first annual "THE VIEW." The VIEW was designed to bring in a panel of female podiatrists to speak to the ladies of AAWP about life as a female physician, money, family, residencies, typical hours, social life, and just about anything else that could possibly be asked. A list of questions assembled by president Nicklya Harris was sent to the panel before hand.

The doctors presenting on that day were chosen by class representation: 1. Single with no kids 2. Married with kids 3. Pregnant 4. Married without kids. Dr. Rachel Rader, a resident from South Miami Hospital, represented married without kids. Dr. Zully Calvo, a resident from Hollywood Medical Center, represented married with kids. Dr. Celine Rezi-Saltani, a resident from Westchester Hospital, represented pregnant. Dr. Liana Korytowski was scheduled to represent single without kids, but unfortunately was unable to attend due to an emergency. All podiatrists on the panel were Barry graduates.

Over 75% of club members were in attendance. Breakfast was served as the panel gave their presentations. Each doctor had a specific message that was brought to the audience. "Always do your best", "You get out of it what you put into it," and, "Always believe in yourself".

Each panelist was presented with a certificate of appreciation, and also a gift certificate for a facial or message from Eurospa Miami. There were also giveaways to the members in attendance. Each lady received a door prize of a Barry University notepad, post-its, and a 2003 calendar. Also there were three raffles. Melissa Marshall, a freshman, won a Barry license plate holder. Emma Denis, a junior, won a free facial. And Tracey Walton, also a junior, won a $50 dollar bookstore gift certificate, which was donated by Dr. Rachel Wood, past president of the national chapter of AAWP. Barry members were very pleased with the success of the panel, and hopes that it will become an annual event.

BUSGMS Spreads Holiday Joy

AAWP sponsored three events for the month of November and one for December: A shoe drive for the homeless through Camillas House, a "feed a family" project through the Miami Rescue Mission, a Bake Sale, and a toy drive.

Under the leadership of Vice-president Ines Apollo for November, club members each donated pairs of shoes for the Camillas House, is a non-profit organization for the homeless. The event was a week long, and only involved club members. Over 50+ pairs of shoes were collected and dropped off at the center.

Also for the month, AAWP members donated money to feed a family/group of 30 people through the Miami Rescue Mission. The money donated provided Thanksgiving dinner for the under privileged.

On the Tuesday before Thanksgiving, the ladies sponsored a bake sale in the lobby of the podiatry building. Items sold included cookies, brownies, donuts, muffins, and more. The club was able to raise almost one hundred dollars.

On Friday, December 13th, AAWP treasurer Lisa Dodenhoff presented bag loads of toys donated by AAWP to the Charlee Children's Depot, a non-profit organization that helps kids of all ages have a merrier Christmas. Towards the latter part of November, members collected toys for delivery. Over 20+ toys were collected for kids of all ages by the members. Upon delivery of the toys, the Charlee Childrens Depot staff were extremely appreciative … hence another successful community event by members of AAWP!

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Evaluating the Athlete

Marybeth Crane, DPM, MS, FACFAS
Mid-Cities Podiatry Associates
Grapevine, TX
www.mcpodiatry.com

So, you want to add a sports medicine component to your practice. Not so fast … athletes are unique individuals to say the least. It takes a basic understanding of the psychology of competitive sports to be a successful sports medicine physician. It also helps in patient interaction if the physician has a strong grasp on the requirements of the specific sport. The increasing popularity of aerobic exercise and the emphasis of the medical community on wellness has increased the number of older, competitive athletes and thereby increasing the number of acute and chronic injuries. The pathogenesis of these injuries can be the result of direct or indirect trauma, or a function of repetitive microtrauma. The mechanics can also have an intrinsic or extrinsic component. Most of us have the basic skills to treat these athletes effectively: a firm grasp of kinesiology and biomechancics. Understanding the basic mechanism underlying the injuries aids the sport medicine physician in developing a logical systematic approach to preventing and managing these injuries. The history and physical examination is the most important component of the management of these injuries. Without an extensive, sport-specific H&P, an underlying causative factor can be easily missed and a delayed recovery with chronic recurrence of the injury is likely.

All athletes are not the same. It is important to first approach your patient and classify their activities. A 74-year-old marathon runner cannot be approached the same as a 16-year-old soccer player. I classify patients in five basic categories:

1) *Child* (under 12)
2) *Adolescent* (under 18)
3) *Competitive adult* (serious collegiate or professional athlete)
4) *Weekend warrior* (competitive, but has another life)
5) *Senior* (50 +, moving just for the sake of moving)

Sub-categories can exist, for example, an obsessive, compulsive weekend warrior trains almost as hard as a competitive adult, but must be approached differently than those being paid to perform. It is important to realize that athletes come in all different shapes and sizes. It is the attitude toward the sport, not the ability or physical attributes that make a true athlete. The six-hour marathoner is just as serious towards their running as the guy that wins the race and should be approached in a similar manner. It is not for you to decide whose sporting activity is an important part of their lives.

After you have classified the patient, comprehensive history of not only the injury, but their training and past and present performances must be obtained. Goals of their training program must also be assessed. Essentials of the history are as follows with additions and deletions for each category of athlete:

- Family History
- Developmental history (child, adolescent)
- Co-morbidities (essential in weekend warriors, seniors)
- Social history (increased stress, new job, goals from exercise)
- History of previous related injuries
- History of present injury (NLDOCAT); (when pain occurs is extremely important, i.e., all day?, only while running?, only after running?, only at night?)
- Training history or recent changes in training patterns
- Increase or decrease in activity levels or level of competition
- Changes in training environment or goals

- Changes in external environment or daily routine (job, school, new home, traveling, etc.)
- Changes in shoe gear, shoe wear patterns, orthotics

A good history will often point you in the right direction, i.e. where to direct and expand your physical exam. The goal of a good history is to concentrate not only on the chief complaint, but on any associated problems or external factors that can alter the normal athletic pattern, predisposing the contralateral limb to injury. Remember, if you listen hard enough and ask the right questions, most people will tell you what's wrong with them. Listen to their theories, even if you think they are crazy. Often times they actually make a little bit of sense and will lead you to the more correct pathogenesis of their problem.

When evaluating the athlete, it is important not to have tunnel vision. You should be comfortable with examining the entire lower extremity and back. Examination of basic posture is important and can identify underlying abnormalities that are not evident in a static exam. The goal of the athletic physical examination is to evaluate the athlete as an individual, to aid the athlete in understanding and achieving their realistic potential, to reestablish an appropriate training program that includes components of flexibility and strengthening exercises, to advise on appropriate shoe gear and need for orthotic devices, and to protect against further injury. This can only be achieved by a complete, comprehensive sorts-specific examination.

BASIC EXAM: The examination should begin with an assessment of vascular, musculoskeletal and neurological systems. Obviously, in seniors it will be more important to assess the neurovascular system in more depth, but in all patients basic pulses, reflexes and gross sensory and motor should be assessed. Body habitus should also be identified because this can be quite important in identifying underlying weaknesses especially in the weekend warrior.

BIOMECHANICAL EXAMINATION: The most important component of the athletic physical is a complete biomechanical exam. This should include examination of the relationships between the components of the lower extremity in a non-weight bearing static position as well as in dynamic gait. Analysis of sports-specific motions also should be included, if relevant.

Static exam: This evaluates the relationships of the various muscles, tendons and joints non-weight bearing.

- Hip internal/external rotation as well as flexion.
- Knee flexion and extension; knee joint instability; patella position and crepitus; relationship of knees with hips and ankles.
- Anterior tibial crest tenderness; Tibial torsion/malleolar torsion.
- Ankle dorsiflexion and plantarflexion with knee flexed and extended; ankle instability measured by anterior draw.
- Subtalar joint ROM
- Midtarsal joint axis and ROM; Forefoot to rearfoot relationship.
- Digital postion, especially Hallux; First ray hypermobility.

Quality of ROM, degree of motion, and any deformities should be noted. Symmetry or lack of symmetry of structures should also be noted.

Posture: general posture should be evaluated in relaxed stance. The position of the shoulders, back, pelvis, hip, thighs, knees, legs, ankles, medial malleolus and calcaneus. The difference between relaxed calcaneal stance position and neutral stance position needs to be evaluated. Presence of a leg length discrepancy or scoliosis should also be noted.

Dynamic functional analysis: Basic gait analysis is not enough. It is important to understand that any alteration in the function of the lower extremities can decrease the absorptive capacities and increase the work load and stress on the various tissues. This can lead to everything from low back pain to hip, knee, shin, ankle, and heel pain. Remember, excessive pronation or lack thereof can lead to a more abrupt transition in the gait cycle, which increases the transmission of force up the body. In addition, pronation leads to internal rotation of the tibia, increased internal rotation of the femur, and subsequent stress on the hip joint. Do not discount lower extremity dysfunction as the causative mechanism for low back pain, hip pain, ileotibial band syndrome, medial knee pain, etc.

It is important to remember that sporting activity places different demands and stress on an individuals body than do everyday activities. That is what makes sports-specific evaluations so important. Gait analysis should be performed barefoot, walking and running; in shoes, walking and running, and in associated kinetic chain activity of the related sport if applicable. This is paramount to assess shoe gear and associated asymmetry of motion. A treadmill with a videotape playback can be quite helpful not only for the practicioner, but for patient education. This can also be utilized for evaluation of orthotic devices.

The athletic history and physical needs to be comprehensive in order to identify abnormal soft tissue, bone, and joint function that may be responsible for the chief complaint injury. It is important to evaluate for biomechanical faults such as excessive pronation, pes plano valgus or pes cavus foot types, joint instability, leg length discrepancies, and muscular-tendinous imbalances that can lead to overuse injuries or increase the risk of traumatic injuries. Previous injuries should also be evaluated to assess their relevance and for the risk of re-injury. Extrinsic factors such as shoe gear, training techniques and compliance, and training surfaces should also be identified. Most injuries are the result of both intrinsic and extrinsic factors coupled with a psychosocial component. Gaining a true understanding of kinetic chain dysfunction is the key to injury prevention as well as proper rehabilitation. There is no cookie-cutter approach that applies to all athletes. Evaluating the complete athlete and the requirements of their specific sport will lead to proper diagnosis, effective realistic treatment and rehabilitation, and a return to sport in better overall physical condition than when they first present to your office. This should be the goal of all sports medicine physicians.

2003 MEMBERSHIP DUES ARE NOW DUE:

Associate Member
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Please make checks payable to AAWP and send to the attention of Pam Sisney, DPM, Treasurer AAWP, 961 Woodcreek Dr., Milford, OH 45150

Rethinking The Common Diagnosis in the Athlete

Lisa M. Schoene, DPM,ATC, FACFAS

Always remember to think "outside the box" when treating conditions that don't get better quickly or as anticipated.

FOREFOOT CONDITIONS: Do not forget to measure feet, get patients into the correct shoe size, shape, and last. Loss of fat pad? Do not forget to add lots of padding to the shoe, inner sole or orthotic.

Treatments that commonly work well with these forefoot conditions are: ultrasound, ice, stretching calf muscles, shoe changes and homeopathic injections instead of cortisone.

MIDFOOT/REARFOOT CONDITIONS: Whether you are dealing with heel pain, PTD, sinus tarsi or tarsal tunnel conditions, always remember to really evaluate the biomechanics. Never forget the neurological influences from the lower back as a culprit to the pain.

Treatments should include physical therapy modalities, strengthening and stretching, as well as orthotic control.

LOWER LEG CONDITIONS: Stress fractures in the tibia or fibula can mimic other conditions, in the lower leg, so be suspicious if your patient's symptoms do not resolve quickly.

Treatments will always work best when combined with lots of strengthening and flexibility work, massage therapy and restriction of activities involving jumping or running.

DON'T FORGET TO LOOK FOR THAT ZEBRA ONCE IN A WHILE!

For more information about the American Association of Women Podiatrists visit www.aawpinc.com

GRASSROOTS MARKETING YOUR PRACTICE:

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Marybeth Crane, DPM, FACFAS
Grapevine, TX • www.mcpodiatry.com

There is a common theme in podiatry today—negativity! Every day I hear from my colleagues how difficult private practice is, how we eat our young as a profession, and how all of us should expect to starve by the year 2005, if we are not already. Some doctors feel the government will bail us out, others are for reforming the current system, but most have just given up.

Contrary to popular belief, most of our profession is still making a better-than-average living, but all of us have to work harder to succeed in a very competitive managed care environment. We are still the best choice for patients with foot related problems. The major problem we, as a profession, have is not managed care, but the lack of public knowledge of what a podiatric surgeon is and how we can help make their lives better. This should be the goal of all practicing podiatric surgeon—to uphold the entire profession and educate the masses. If you can find a way to accomplish this in your community, you will be successful!

Success does not fall into your lap anymore. Patients do not just walk in the door because you hang your shingle. It is important to have a plan and follow through. If you are the only podiatric surgeon for 50 miles around your office, this discussion can still help you maximize your patient load. If you have 25 podiatric surgeons within 5 miles of you, pay attention! You can still be a success if you follow a simple plan!

1. EVALUATE YOUR PRACTICE
2. DEFINE YOUR GOALS
3. DEVELOP A STRATEGIC PLAN
4. FOLLOW UP

Plan details in next bulliten … AAWP to the rescue …

Editor's Note: This is the first installment in a series of articles relating to Marketing which Dr. Crane will be contributing.

2002 Scholarship Award Winners

Karen Glandon, DPM

Podiatric Medical students are eligible for two types of scholarships through the AAWP. The Founders Scholarships available from the AAWP are in the amount of $1000.00. The recipients selected for 2002 include **Elizabeth Bass** of TUSPM and **Jill Bruneau** of OCPM. NYCPM had three recipients: **Mital Patel, Yolanda Ragland** and **Vilayvanh Sysounthone**. Applications for 2003 are available online at www.aawpinc.com and are due June 2003. Should you wish to contribute money toward the distribution of the Founders Scholarships, please contact Pam Sisney, treasurer of AAWP.

The Fund for Podiatric Medical Education scholarships are distributed via the APMA. The FPME awarded 134 scholarships in 2002. The AAWP sponsored the awards for five recipients: **Jill Bruneau (OCPM), Suzanne Henke (CCPM), Megan Lawton (BUSGMS), Melissa Selner (CCPM)** and **Lisa Dodenhoff (BUSGMS).**

For applications for FPME scholarships, please contact the APMA at 1-800-ASK-APMA. If you wish for your donated monies to be dedicated to the AAWP Scholarships of the FPME, please indicate this desire when you make your contribution to the APMA.

The High Maintenance Patient: The Athlete

Lisa M. Schoene, DPM,ATC,FACFAS

Athletes come in many shapes, sizes, ages and, skill levels. Stresses can be high, when you have an obsessive-compulsive personality, many of these patients have type A personalities, and they can have disordered eating, workout obsession, and/or emotional problems as well.

These athletes are usually proactive, well educated on their condition, and usually will be compliant in their treatment.

Treatment needs to be focused, aggressive, but conservative, very well rounded and may need to incorporate different modalities or disciplines i.e.: physical therapy, acupuncture, massage therapy, and or chiropractic care.

Stay focused, optimistic, aggressive, and in control of your treatment plan and your athletic patients will be back on track ASAP!

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