Overview of
Outpatient Podiatry
Clinical Services
at A.N.M.C.

Charles C. Edwards, DPM

Director of Podiatry

Alaska Native Medical Center

Alaska Native Tribal Health Consortium

July 29, 2014

Podiatry Services

Our Team Includes

- 2 Surgical Podiatrists
  - Karl A. Boesenberg, DPM
  - Charles C. Edwards, DPM
- 1 RN Case Manager
  - Carrie A. Nelson, RN
- 1 Certified Medical Assistant
  - Jean David, CMA

Podiatry Services

Our Usual Weekly Clinic Schedule

- Monday 9a-12p and 1p-4:30p
- Tuesday 1p-4:30p (mornings we are in O.R.)
- Wednesday 8a-12p and 1p-4:30p
- Thursday 8a-12p and 1p-4:30p
- Friday 8a-12p and 1p-4:30p

Podiatry Services

Special Considerations before Referring

- Podiatry has NO ANMC admitting privileges
  - Do not refer individuals requiring admission
  - Call the on-call Hospitalist or E.D.
- Podiatry does NOT care for foot/ankle trauma
  - Refer to Orthopedic Surgery
- Medicaid does NOT pay for Podiatry in patients from ages 18 through 65; all referrals screened by Podiatry RN Case Manager
  - Refer denials to Orthopedic/General Surgery

In Person Visits

For optimal patient visits, the following clinical workup is recommended before the referral/visit:

- Progress notes from referring provider should have clear details about history, implemented treatment to date, and clinical exam findings. We expect First Line care to have been implemented and failure of that care to be documented before accepting referrals
- Appropriate labs for respective conditions (e.g. Uric Acid, ESR, CRP for gouty arthritis)
- Appropriate X-rays; we prefer 3 Weightbearing views of involved foot (AP, oblique and lateral)

Podiatry Services

We provide an array of services by priority ranking

- 1st Priority
  - Diabetic foot/limb prevention and preservation care
    - High Risk feet (loss of protective sensation / pulses)
      - Qualify for Diabetic Shoes, preventative corn, callus and toenail care in Podiatry Clinic Q2-3Mo
    - Low Risk feet (intact protective sensation / pulses)
      - Do not qualify for diabetic shoes or routine preventative care (corn, callus, toenail care); however we do perform routine diabetic care for those individuals who cannot do it themselves or have no one to help them at home

Podiatry Services

We provide an array of services by priority ranking

- 1st Priority
  - Diabetic Wounds
    - We manage diabetic wounds, but are challenged by:
      - Only two providers, no mid-level providers
      - Three total exam rooms
      - Schedule backlog means limited ability to see wound patients more often than every 2-4 weeks

Please do not refer non-diabetic foot wounds; those wounds do not have the same risk for amputation as diabetics, and ANMC has a general Wound Clinic that can handle other wounds more timely than we can.

Podiatry Services

We provide an array of services by priority ranking

- 2nd Priority: We only want to see these conditions after the primary care providers have implemented appropriate first line conservative measures and the chart indicates these have failed to improve condition:
  - Arthritis
  - Bunions
  - Fungal toenails*
  - Hammer toes
  - Ingrown toenails*
  - Masses
  - Plantar fasciitis

Only refer fungal nails or RECURRENT ingrown toenails for permanent removal, and even then only if patient is a willing and appropriate surgical candidate!

Podiatry Services

Service we do not provide: We offer no different treatment options than a primary provider might for these conditions, so please do not refer to Podiatry

- Acute pain (<30 days)
- Athlete's Foot
- Blisters
- Fractured toe(s)
- Moles
- Non-diabetic toenails
- Skin rashes
- Warts

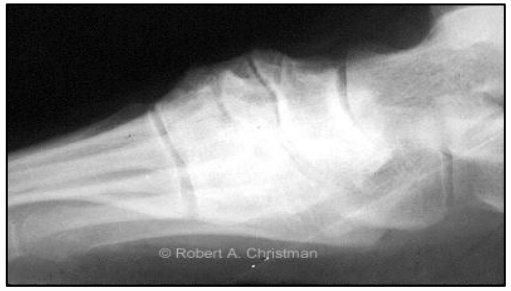
* By NOT referring these individuals, there will be more clinic space freed up for Priority 1 and 2 patients!

* Annual diabetic foot exams should be done by the Primary Provider; and only referred to Podiatry if abnormal.

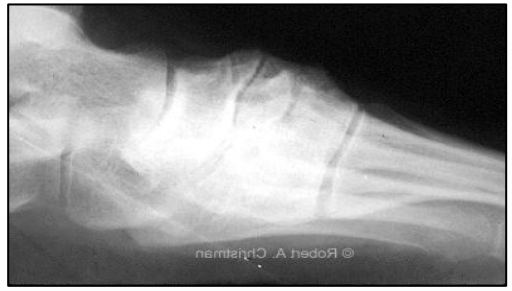
Podiatry Services

Referral Guidelines

- Podiatry cannot accommodate non-diabetic toenails; please do not refer these cases.
- Podiatry does not offer in-office procedures (e.g. toenails) for patients <13 years of age, and will not use its limited O.R. block time for these.
- The following slides outline first line treatment for the most common conditions referred to Podiatry. Please document failure of this first line care prior to referring to Podiatry.

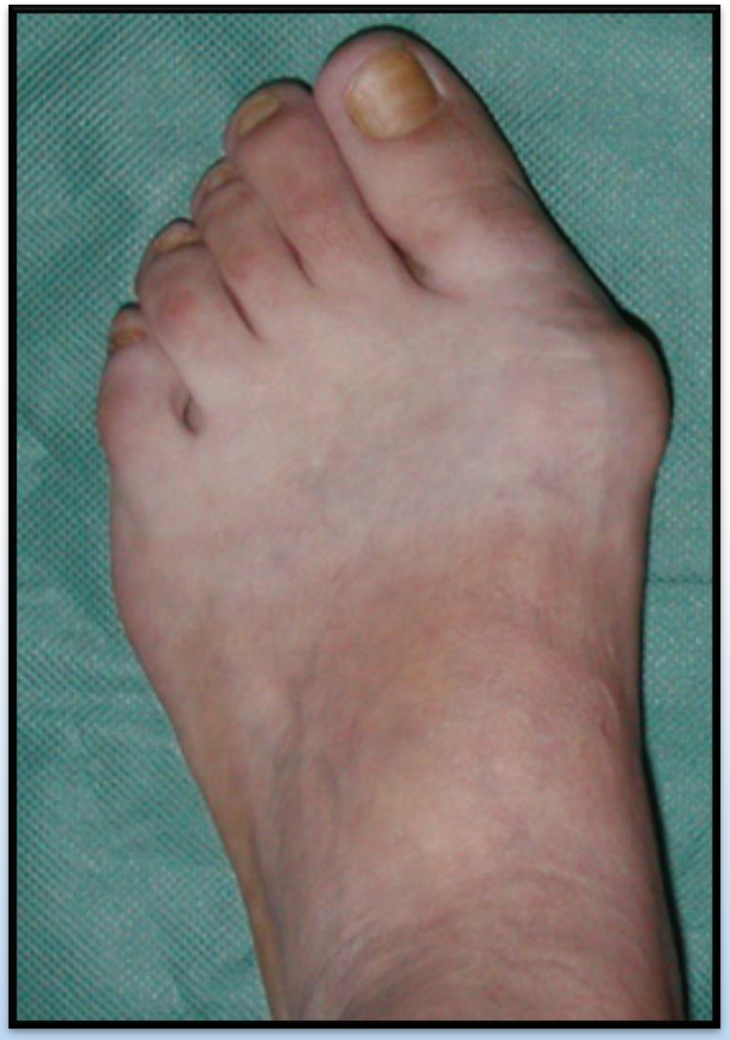


Arthritis



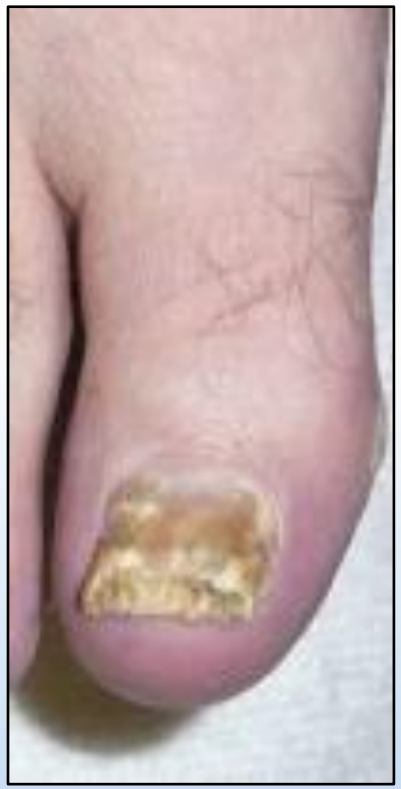
1. SHOES: most arthritic conditions are only painful when wearing flimsy or tight-fitting shoes. Do not refer to Podiatry unless patient already in appropriate shoes. Podiatry does NOT provide shoes to patients for arthritis.
2. ARCH SUPPORTS: OTC orthotics can stop the progression of arthritis and limit pain; Do not refer to Podiatry unless the patient is in pain despite use of OTC arch supports.
3. SURGERY: if the above fail; please obtain 3 weightbearing X-rays of the involved foot (AP, Oblique, Lateral) and refer to Podiatry. We will only recommend surgery for an appropriate candidate (details in upcoming slide).

Bunions



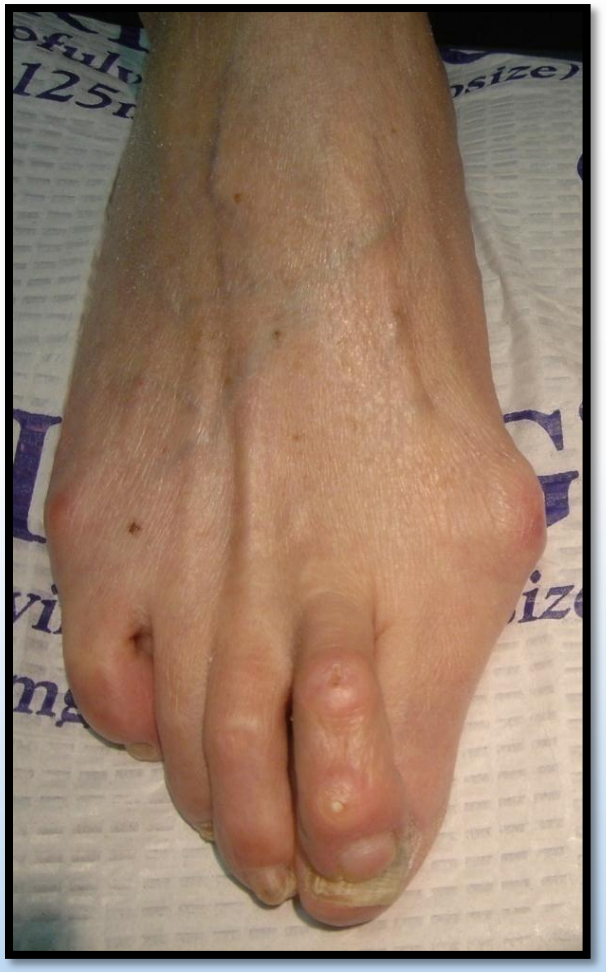
- SHOES: most bunions are only painful when pinched or compressed in tight-fitting shoes. Do not refer to Podiatry unless already wearing wide toe-box shoes. Podiatry does NOT provide shoes to patients with bunions.
- ARCH SUPPORTS: OTC orthotics can stop the progression of bunions and limit pain; Do not refer to Podiatry unless the patient is in pain despite use of OTC arch supports.
- SURGERY: if the above fail; please obtain 3 weightbearing X-rays of the involved foot (AP, Oblique, Lateral) and refer to Podiatry. We will only recommend surgery for an appropriate candidate (details in upcoming slide).

Fungal Toenails



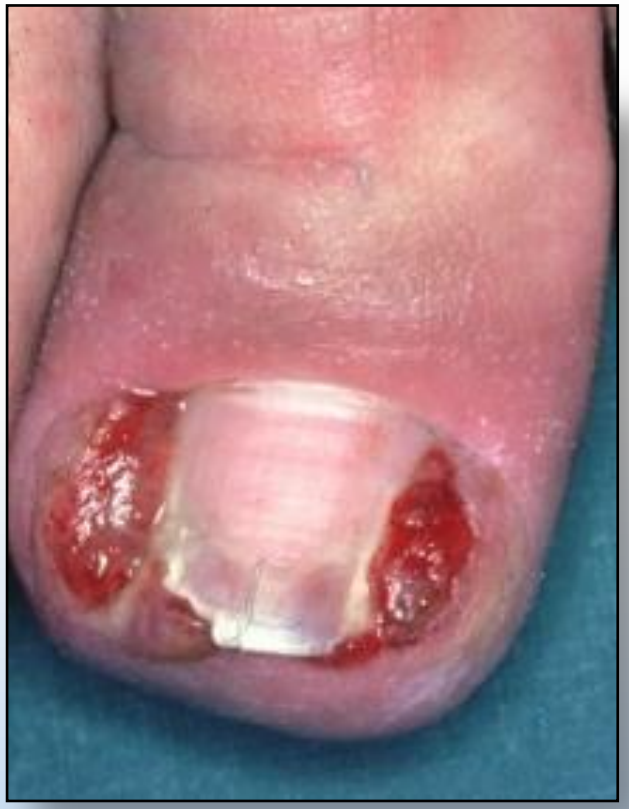
- HYGIENE: daily soap/water, dry powder between toes, frequent sock changes, clean dry shoes
- SHOES of proper length + deep toe box will keep pressure off thick toenails and nearly always eliminate pain without risks of further care.
- TOPICAL/OTC treatment (anecdotal evidence only): daily application Vicks or Tea Tree Oil for 1 to 2 years can thin nails / reduce crumbling.
- ORAL treatment: check LFT's; if normal, advise no EtOH and Rx Lamisil 250 mg PO QDay x 90 days, or Fluconazole 200 mg PO Qweek x 24 weeks (contraindicated with Statins).
- SURGERY: if above fails AND patient desires permanent surgical removal AND is an appropriate candidate (details in upcoming slide) refer to Podiatry for permanent removal.

Hammer Toes



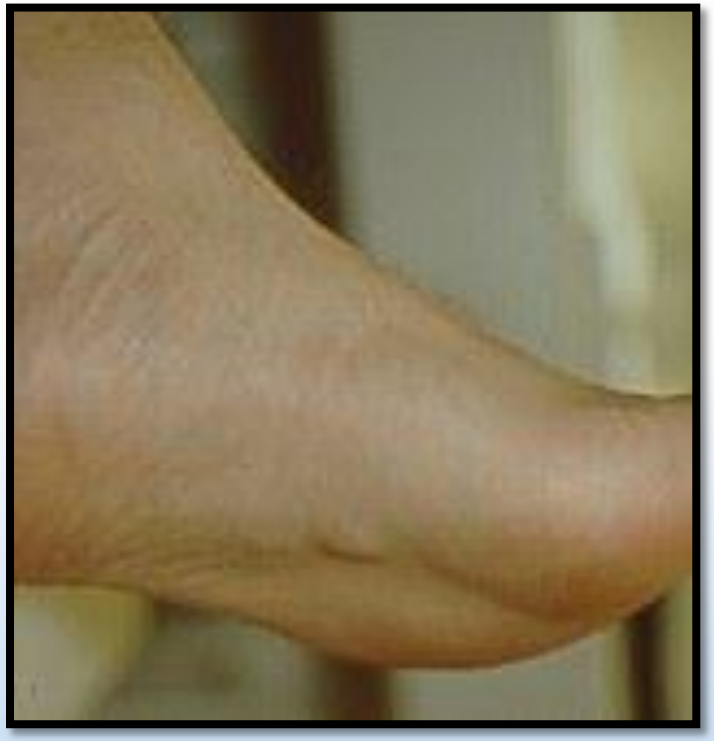
- SHOES: most hammer toes are only painful when pinched or compressed in tight-fitting shoes. Do not refer to Podiatry unless already wearing appropriate deep toe-box shoes. Podiatry does NOT provide shoes to patients with hammer toes.
- ARCH SUPPORTS: OTC orthotics can slow the progression of HT and limit pain; Do not refer to Podiatry unless the patient is in pain despite use of OTC arch supports.
- SURGERY: if the above fail; please obtain 3 weightbearing X-rays of the involved foot (AP, Oblique, Lateral) and refer to Podiatry. We will only recommend surgery for an appropriate candidate (details in upcoming slide).

Ingrown Toenails



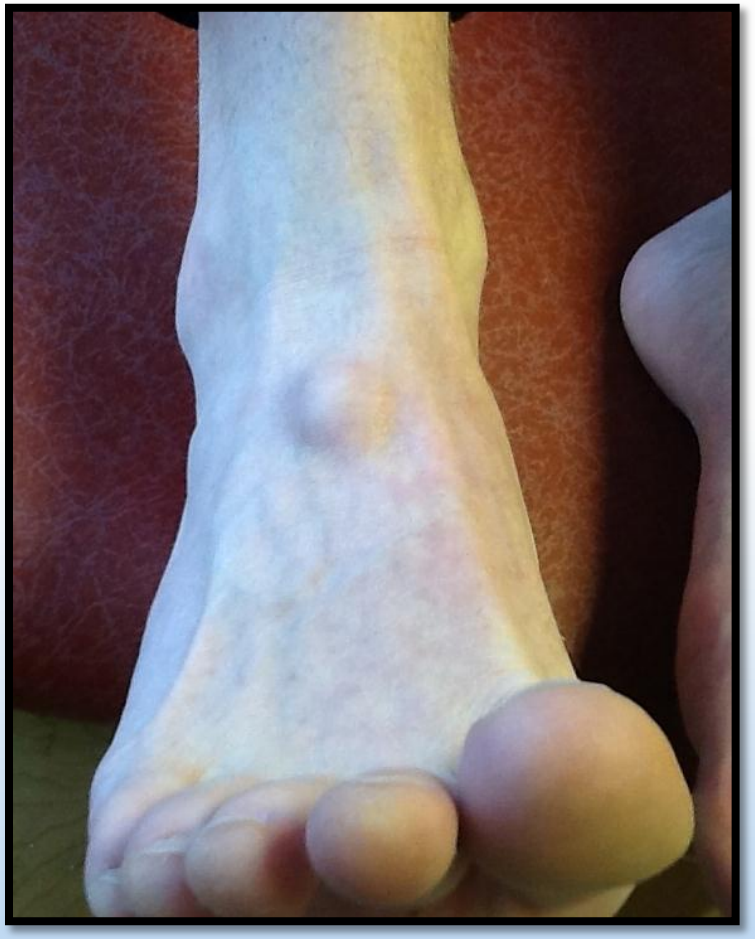
- HYGIENE: most ingrown toenails are caused by aggressive trimming or tearing nails too short. SOAKS: 1/3 cup epsom salt in basin with warm (not hot water) for 15 minutes; dry; leave open to air when indoors (if clean) or cover when outdoors / wearing socks and shoes.
- TEMPORARY REMOVAL should be done at the initial visit with PCP or ED; it is not reasonable to have the patient wait several months for Podiatry to temporarily remove toenails. 50% chance of recurrence ingrown nail.
- SURGERY: if the above fail; please refer to Podiatry for PERMANENT toenail removal. We will only perform surgery for an appropriate candidate (details in upcoming slide).

Masses: Fibroma



- SHOES: most fibroma are only painful in flimsy shoes or sandals. Do not refer to Podiatry unless condition is painful despite wearing appropriate stiff-soled shoes.
- ARCH SUPPORTS: OTC orthotics can stop the progression of fibroma by limiting over-stretch of the plantar fascia, and thereby limit pain; Do not refer to Podiatry unless the patient has pain despite OTC arch supports in stiff-soled shoes.
- STRETCHING: Increase flexibility in plantar fascia.
- INJECTIONS / SURGERY: if the above fail; please refer to Podiatry for consideration of custom molded orthotics. We will only recommend surgery for an appropriate candidate (details in upcoming slide).

Masses: Ganglion

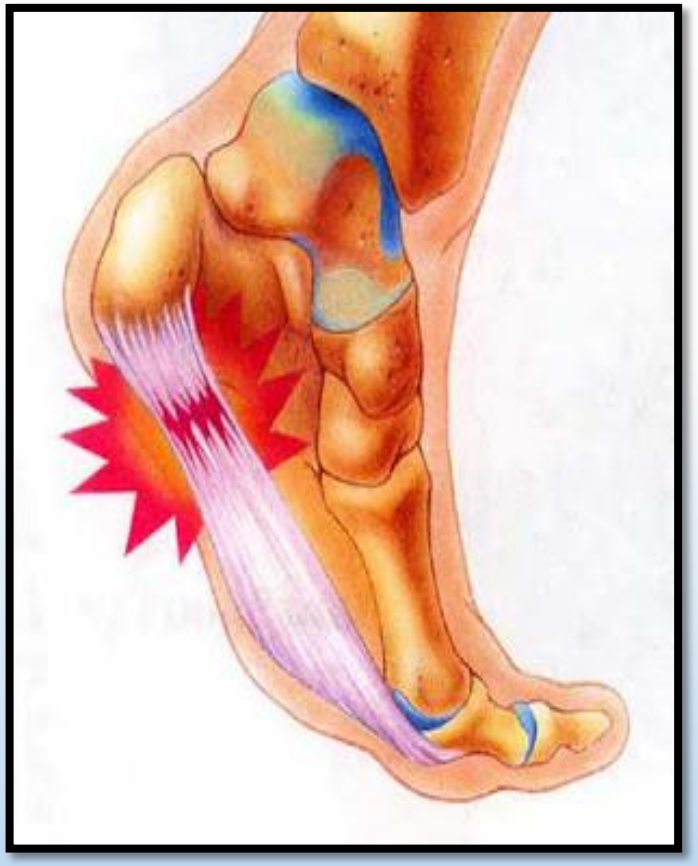


- SHOES: most ganglions are not painful, and those that are painful are usually only so when pinched or compressed in tight-fitting shoes. Do not refer to Podiatry unless condition is still painful in appropriate deep shoes with altered lacing pattern to limit overlying pressure.
- INJECTIONS / SURGERY: if the above fails; and the mass is tender, please obtain 3 weightbearing X-rays of the involved foot (AP, Oblique, Lateral) and refer to Podiatry. We will likely only recommend surgery for an appropriate candidate (details in upcoming slide) if aspiration fails .

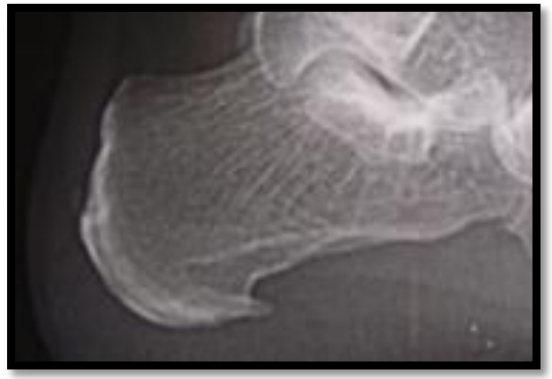
Masses: Neuroma

- SHOES: most neuroma are only painful when pinched or compressed in tight-fitting shoes. Do not refer to Podiatry unless condition still painful in appropriate wide toe-box shoes.
- ARCH SUPPORTS: OTC orthotics can stop the progression of neuroma and limit pain; Do not refer to Podiatry unless the patient has pain despite OTC arch supports in sensible shoes.
- INJECTIONS / SURGERY: if the above fail; please obtain 3 weightbearing X-rays of the involved foot (AP, Oblique, Lateral) and refer to Podiatry. We will only recommend surgery for an appropriate candidate (details in upcoming slide).

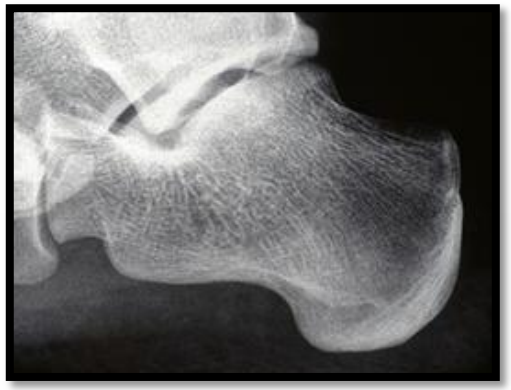
Plantar Fasciitis



- SHOES: use of sensible shoes both indoors and outdoors usually eliminates pain. Podiatry does NOT provide shoes to patients with fasciitis.
- ARCH SUPPORTS: OTC orthotics are the principal treatment for fasciitis, and prevention of recurrent fasciitis. Do not refer to Podiatry unless the patient is still in pain despite OTC arch supports in sensible shoes.
- STRETCHING: particularly after rest / sleep.
- ORAL NSAID's for 7-14 days help get over flares.
- INJECTIONS / SURGERY: if the above fail; please obtain 3 weightbearing X-rays of the involved foot (AP, Oblique, Lateral) and refer to Podiatry. We will only inject, and less likely surgery, for appropriate candidates (details in upcoming slide).



Plantar Fasciitis



Important Fact Re: Heel Pain

Heel Spurs do ***NOT*** cause pain. They are commonly found on asymptomatic patients; and are often absent in symptomatic patients. They are a sign of mechanical instability (i.e. need for arch support). It is the inflammation of the muscle and ligament tearing from bone that causes pain. Please do not tell your patients they have a heel spur or need one removed. Please do not call this 'Heel Spur Syndrome'; use the more accurate Plantar Fasciitis / Fasciosis terms.

Appropriate Surgical Candidates

1. Controlled blood sugars: Hg A1c < 7.0%
2. Controlled psychiatric disorders
3. No smoking tobacco for 6 months
4. No alcohol dependence
5. Stable home to convalesce
6. Reliable escort
7. Reasonable expectations

** Please remind all patients that there is no surgery that cannot make their foot worse! **

Field Clinic

At this time Podiatry does not offer Field Clinics

Video Teleconferencing Visits

Digital photography / standard Telepodiatry is usually most appropriate for Podiatry; but there may be times VTC Visits help:

- Post-op visits / surgical incision inspection
- Wounds, ulcers, infections

Electronic Consultations using AFHCAN

Appropriate Telehealth Consults are diabetic wounds, those individuals who have failed to respond to first-line therapy as listed above, and post-op patients.

A detailed recent History, list of attempted Treatments to date, and detailed Clinical Exam are helpful for Telehealth Consults. Digital photographs are very helpful

Questions?

Resources/Links

- Complete Diabetic Foot Exam

http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsFCHowto