AMERICAN SOCIETY
PODIATRIC
MEDICAL ASSISTANTS

JOURNAL

3RD QUARTER | 2018

Knowledge That Moves You Forward!

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FROM THE PRESIDENT

Hello ASPMA members!

My name is Elizabeth Rudy, PMAC. I am the President of the ASPMA, serving a fourth term. I am honored to continue to serve as your president!

We have had a very exciting year so far with continuing education, conferences, and more! We have continued to grow as an organization and could not have done so without your help!

We have had many ups and downs while the organization continues to grow, but please remember that all of the board members are diligently working hard to achieve the goals and requests of our members. We appreciate the patience you have with the ASPMA while we work through this together. We ask if any member or future member has any questions regarding membership or certification, please contact the ASPMA first. There are many changes with conferences and exam offerings this year and we do not want you to miss out on any opportunities. Please never hesitate to contact any board member for additional information!

Additionally, we have open board positions that we encourage any PMAC (certified assistant) to apply! To see a list of current board positions and how to apply, please visit us at www.aspma.org. We would love to hear from you!

To serve as a reminder, please remember that any assistant who wishes to certify, may also do so online at www.aspma.org. Please visit our page if you have any questions!

We have many new PMAC's this year and have welcomed dozens of new ASPMA members! The ASPMA Board of Directors welcome you to the most exciting and fastest growing assistants' organization!

Let's continue to have a great year!!

Respectfully yours,

Elizabeth Rudy, PMAC
ASPMA President

AMERICAN SOCIETY PODIATRIC MEDICAL ASSISTANTS

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SUBMISSIONS
Interested in having an article published in the ASPMA Journal? ASPMA members may submit articles for publication in the ASPMA Journal. Articles should be no more than 500 words and must be submitted in electronic format. The Journal Editor reserves the right to edit or refuse any article submitted for publication.

Please send your articles to Cheryl at cherylbpmac@gmail.com.

CHANGE OF ADDRESS
Please notify ASPMA Membership Chair by sending your old address and new address. Notifications should be sent ASAP as not to delay any Journal or letter mailings from ASPMA.

Tina Phelps
Membership Chair
602 Bradley Dr. Apt A, Fortville, IN 46040
Email:tinaphelps@yahoo.com

2018-2019 ASPMA OF OFFICERS

PRESIDENT
Elizabeth Rudy, PMAC
Hammond, LA

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Charleston, SC

VICE PRESIDENT
Tara Brown, PMAC
North Brunswick, NJ

SECRETARY
Kim Heineman, PMAC
Omaha, NE

EXECUTIVE DIRECTOR
Karen Keathley, PMAC
Itasca, IL

NEWS & NOTES

2018-2019 ASPMA BOARD MEMBERS

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Suffolk, VA

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Cheryl Bailey, PMAC
Holt, MI

Welcome Our New Members!

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Kristin Brock
Alison Parlin
Lillian Tucker
Tilisha Gallman
Kara Cary-Held
Rebecca Stueck
Robin Dietrich
Nathalie Sanchez
Ian Scholl
Tricia Goodeve
Ursula Troop
Ariel Grant
Sasha Singleton
Anastasia Rising
Heather Burley
Dorce Yvens-Star
Melissa Jameson
Brianna Bavaro
Ronda Morrow
Cathy Eakin
Stormy Wooten
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Alicia Rivera
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Heather Werner
Charmale Tookes
Barbara Snead
Angelia Heowener
Arielle Kuhn
Elizabeth Mertel
Carolyn Handley-Kleindl
Dana Paris
Kirsten Ness
Tiffani Lockhart
Latoya Hill
Tiffany Olivo
Heather Pasquale
Brittney Meagher
Nicholas Savant
Jennifer L. Young
Kristina Westman
Alexandra Dick
Manisha Horton
Nicole Denton
Charles Hoover
Bianca Concetta Alfaso
Emily Watterston
Amity Funk
Taylor Robb

Qualifying and Examining Members Receiving Certification

ONLINE CERTIFICATION

Syrita Vaughn, PMAC
Chasity Graham, PMAC
Emily Grady, PMAC
Kayla Csencsits, PMAC
Orialis Acevedo, PMAC
Madonna Wyatt, PMAC
Sivia Bautista, PMAC
Jill Zimmermann, PMAC
Kelsey Atkinson, PMAC
Stephanie Martinez, PMAC
Carina Mosso, PMAC
Kelli Johnson, PMAC
Maureen Wynne, PMAC
Thomas Yanushefski, PMAC
Sarah Marchand, PMAC
Bethany Repass, PMAC
Heather McCarron, PMAC
Brandi Wise, PMAC
Jennifer Thompson, PMAC
Amber Honeysett, PMAC
Tesia Norton, PMAC
Jenna Burchfield, PMAC
Emily Brandt, PMAC

NEWS & NOTES

NEW PMAC AT APMA NATIONAL

Emily Kiren, PMAC

Caitlyn Kuhn, PMAC

Heather Eader, PMA

Lillian Tucker, PMAC

Yvonne, Ricke, PMAC

Annie Hall, PMAC

Tilisha Gallman, PMAC

Board Positions

Mtembers who are interested for a position must be currently employed by a podiatric physician with current APMA membership. Also, have achieved PMAC status (either clinical or administrative) and be current on their membership dues and recertification.

President-Elect

To apply for this position member must have served on the Executive Board for one year.
Responsibilities include but are not limited to:

-Work closely with the President to learn the role of the President and the affairs of the ASPMA
-Assist the President as requested
-Automatically succeed to the office of President at the 2020 Midwest Podiatry Conference
-Must attend the 2019 Midwest Podiatry Conference and National Conference in Salt Lake City, UT; May need to attend other conferences as needed

Vice President

Responsibilities include but are not limited to:

-Serve as the Chair for the Bylaws Committee
-Assist the President as requested
-Perform any duties assigned by the ASPMA Board
-Must attend the 2019 Midwest Podiatry Conference and National Conference in Salt Lake City, UT; May need to attend other conferences as needed

Secretary

Responsibilities include but are not limited to:

-Serve as Secretary at all Board meetings
-Record, maintain, and distribute the minutes from all Board meetings
-Maintain the Secretary binder and recorder
-Send out all correspondences
-Assist the President as requested
-Perform any duties assigned by the ASPMA Board
-Must attend the 2019 Midwest Podiatry Conference and National Conference in Salt Lake City, UT; May need to attend other conferences as needed

3 Board of Directors

This is an intern position.
Responsibilities include but are not limited to:

-Assist Board Members with their duties at meetings (ie. setting up meeting rooms, welcoming and directing assistants, assisting speakers, handing out and collecting evaluation forms, and etc)
-Perform any duties assigned by the ASPMA Board
-Must attend the 2019 Midwest Podiatry Conference and National Conference in Salt Lake City, UT; May need to attend other conferences as needed

Scholarship Committee Chair

This position is not a Board Position, you will not have any voting privileges. Also, you will not have to travel or attend any Board meetings.
Responsibilities include but are not limited to:

-Send out scholarship letters and applications
-Review all scholarship applications
-Send out award letter(s) to recipient(s)
-Follow up with scholarship recipient(s) to ensure they have received scholarship

AMERICAN SOCIETY PODIATRIC MEDICAL ASSISTANTS

ASPMA BOARD APPLICATION 2019-2020

Complete the application and return it along with:

- Your Curriculum Vitae/Resume
- A letter stating why you would value this position, and what you feel you could add to the future of the organization.
- **TWO** letters of support/recommendation **one** from your physician/employer, **one** letter of recommendation from professional or personal.

Name: _____

Home Address: _____

City, State, Zip: _____

E-mail Address: _____

Phone Number: _____

Cell Phone Number: _____

Employer: _____

Employer's APMA#: _____

Employer's Address: _____

City, State, Zip: _____

Employer's Phone: _____

Year you obtained PMAC status: _____

All information can be emailed to: tara.antoinette@gmail.com

Please put "ASPMA Board Position" in the subject line of the email

ALL applications must be submitted by December 1st 2018

Second Annual APMA Quiz bowl

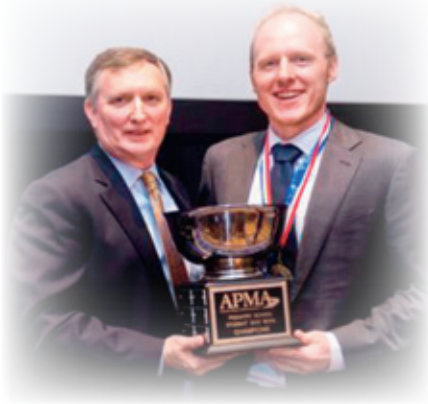
By Cheryl Bailey, PMAC
Journal Editor, ASPMA

The American Society of Podiatric Medical Assistants (ASPMA) is very proud to be involved again for the second annual APMA quiz bowl. Which will be held:

Date: Saturday, July 13, 2018
Time: 2:00–4:00 p.m.
Location: National Harbor 2-3 in the convention center of the Gaylord National
SESSION: Podiatry School Student Quiz Bowl during the APMA National Conference.

We are honored to be donating the prizes in the amounts of two-thousand dollars towards the contestants this year.

Nine Podiatry Schools are being represented at the quiz bowl this year, like last year it will be informative and entertaining. Student contestants are:



HyunJi Boo - *New York College of Podiatric*
Medicine, Zachary P. Booth - *Midwestern University Arizona School of Podiatric Medicine*
Trent R. Brookshier - *Western University of Health Sciences College of Podiatric Medicine*
Rachel E. Egdorf - *Des Moines University College of Podiatric Medicine and Surgery*
Michael Flores - *California School of Podiatric Medicine at Samuel Merritt University*
Turenne Mackenley Metayer - *Barry University School of Podiatric Medicine*
Brandon Rogers - *Kent State University College of Podiatric Medicine*
Dong Yu - *Temple University School of Podiatric Medicine*
Mike Hurst - *Dr. William M. Scholl College of Podiatric Medicine at the Rosalind Franklin University of Medicine and Science*

The American Society of Podiatric Medical Assistant's (ASPMA) board members will once again be wearing shirts for the schools and cheering on the student contestants. We are looking forward to the questions again this year. As podiatric assistants ourselves, it's nice to know we also have a lot of this knowledge and knew the answered to questions the students didn't know. This stems from great DPM's that we all work and are associated with whom are also all APMA members. In my opinion podiatry is a great field, where knowledge can be endless, and rewarding.

Please make sure to come join in the fun and cheer on the student contestants for the 2nd Annual Podiatry School Student Quiz Bowl during the APMA National Conference. We hope to see you there.

SAVE THE DATE

JULY 11–14, 2019
SALT PALACE CONVENTION CENTER
SALT LAKE CITY, UT

WWW.APMA.ORG/THENATIONAL

National News!

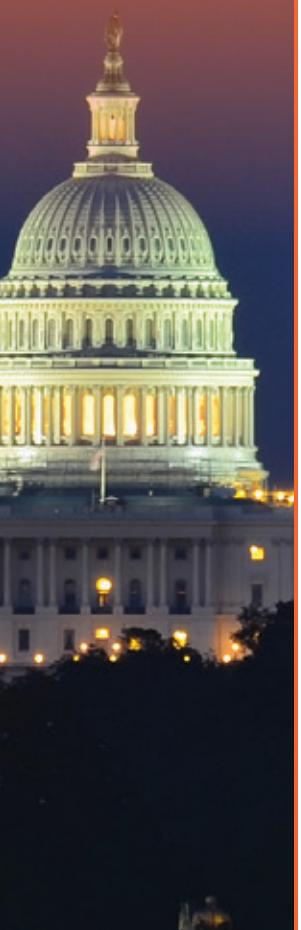
By Elizabeth Rudy, PMAC

Greetings! I want to take this time to brag about how wonderful the APMA National conference was past July in Washington, D.C. We had a great turn-out of assistants who attended the conference and were eager to listen and participate in the many new and exciting lectures! I, personally, loved the time we spent in D.C. learning new things!

We were excited to be a part of the APMA 5k, which took place on the Saturday morning, prior to lectures. There is really no better way to start the day than to begin with an exhilarating harbor view run while trying to silently beat out the nearest DPM running beside you! Well, that was my goal at least. I take pride in being able to participate in the 5k run every year. The funds from the run benefit the Podiatry students' educational fund, which makes the joy of it even more exciting!

For the second year, the ASPMA also largely participated in the Student Quiz bowl competition, where students from all 9 Podiatry schools compete for prize money and bragging rights! The ASPMA had a wonderful time making support posters and wearing school t-shirts to help cheer on the students. The attendance at the quiz bowl this year was immense- even more so than last year. We thank EVERYONE who helped support the students with us and make this event memorable. The quiz bowl competition is definitely worth seeing. Next year, come test your knowledge! I know there were several questions that I knew the answers to.... And some that I didn't

We hope to see you next year!!



A SHOW OF SUPPORT FOR PODIATRIC MEDICAL STUDENTS

THE APMA HOSTED IT'S 8TH RUN/WALK EVENT

On your mark, get set, RUN...or walk (leisurely, like I did!)

By Michele Bradice, PMAC
President-Elect, ASPMA

The APMA hosted its 8th **Team APMA 5K Run/Walk** event at the 2018 Annual Scientific Meeting (The National) on Saturday, July 14, 2018. The race took place on site at The National's host property, the Gaylord National Hotel & Resort, at 6am.

As a Board, the American Society of Podiatric Medical Assistants used this event as a team-building exercise...more like a leisurely morning stroll with girlfriends. It was a clear day with a warm breeze blowing off the harbor. Among 101 runners, our little group of 8 gathered around for warm-up stretches and selfies...and took our final sips of coffee.

We leisurely walked the 3.1 miles and watched as some runners had already looped around and were making their way to the finish line. The sun rose and the temperature climbed steadily, which provoked us to pick up our pace.

At the mid-point turn-around we took advantage of a photo-op to admire the rising sun over the city. Knowing that the 1st runners had already crossed the finish line we decided to briskly walk the remaining mile and a half.

Proudly displaying bib #831, I crossed the finish line 99th (out of 101)...in a record-setting 58:12! Clearly, I'm not a competitive person. I'm more of a team-oriented people-person and thoroughly enjoyed a morning stroll with my ASPMA board members to benefit podiatric medical students. The truth is I am terribly envious of those who can run but we will show up every time to show my support. I offer up my apologies to the 1st place winner: **John Paul Sevcik**, who completed the race in 16:36...I'm sorry you had to wait for me. Next year, I'll pick up the pace (slightly)...game on!

Finishing 2nd & 3rd places respectively were: **Golden Harper** (16:40) and **Michael Rushton** (19:00).

Thanks to the following:

The APMA – for bringing us together for a good cause!

Shirt Sponsor **– ASICS**

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General Sponsors **– Bako Diagnostics; Spenco Medical by Implus; Vionic Group, LLC, GES; Marlinz Pharma; Projection; Strata DX**

Why Efficiency Is Not Only The Key – it's NECESSARY!

By Michele Bradice, PMAC
President-Elect, ASPMA

Office Manager
Carolina Foot Centers

Charleston, South Carolina
Mishamosha1030@gmail.com

I am the Office Manager of a multi-physician podiatry practice. Some days I compare my job to an episode of the Three Stooges! Luckily, most days I compare my job to that of a conductor…of a fine-tuned symphony. Hit it, Maestro…

The concept of 'efficiency' is sometimes lost in the day-to-day functioning of a medical specialty practice. We take for granted that the phone rings, we set-up patient appointments, patients come in, get seen by the Doctor, helped by the medical assistant, check-out, and leave. We clean the room, chart the note, close the file, etc. While these tasks may seem efficient at the time, have you ever wondered if you are just on "auto-pilot"? Do you think certain day-to-day operations eventually become robotic? Don't let efficiency get lost in your practice.

Let's start with the front desk, the receptionist, or as my office titles it, "The Director of First Impressions". This is an extremely important position in a medical office. This person is the first voice or face that the patient ever hears or sees. The patient has already formed an opinion of the practice within the first 10-seconds of interacting with this person. When setting appointments, the receptionist must ensure that all of the information is accurate, especially patient demographics and insurance information.

Does your office verify benefits before the patient even shows up for their appointment? Well, they should. This is an extremely efficient way to treat the patient. The doctor will already know what the insurance will or will not cover. If the patient needs a brace, for instance, one can be dispensed right there. Otherwise, think of the alternative. You would have to ask the patient to wait while we called the insurance company to find out DME coverage. The same goes for injections, x-rays, etc. Prior insurance verification is not only efficient – it is NECESSARY!

Let's move on to back office choreography…

The medical assistant rooms the patient. Does he/she obtain as much information as possible? If they are diabetic, do we ask what their last blood sugar was? Do we ask them to rate their pain on a pain-scale? Do we ask where the pain is? How long the pain has been present? If there was trauma to the area? If the patient has any questions or concerns for the Doctor? If they need a medication refill? If they are having any new issues with their feet? Do they need help taking off their socks and shoes?

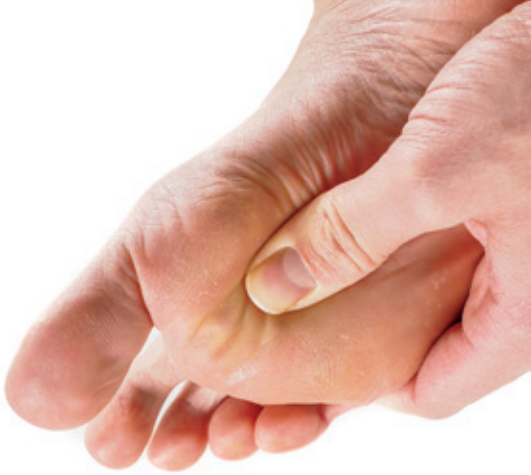
If all of this information is translated to the doctor *before* he/she sees the patient, that is *efficiency*! Furthermore, if it is well-documented, you're already well on your way to efficient MIPS/MACRA reporting. Which is NECESSARY!

Take it one step further….anticipate the next step. Do you think this patient will need an x-ray? Do you think the Doctor will use the ultrasound on this patient? If so….set it up. Get it ready. This is EFFICIENCY at its finest.

The check-out process: How efficient is yours?
When the patient checks out it should already be known (approximately) how much they owe and it should be collected at the time of the visit. A follow-up appointment should always be scheduled before the patient leaves. Patient retention is vital to a medical practice.

Obviously, every office is run differently. Regardless of the order of operations, efficiency is KEY. There are always areas that can benefit from being more efficient. Tackle one task every month or so and fine-tune it. You will see a smooth running office in no time at all!

Clearly there are many more facets to operating an extremely efficient office. Keep striving to give your patients a five-star experience. Strive to make your office run like a well-oiled machine. Talk to other offices. Network with other practices. Use every resource available to you. If things aren't working, change them. Efficiency is not only the key – it is NECESSARY for a solid practice.



Why diabetics need a PODIATRIST!

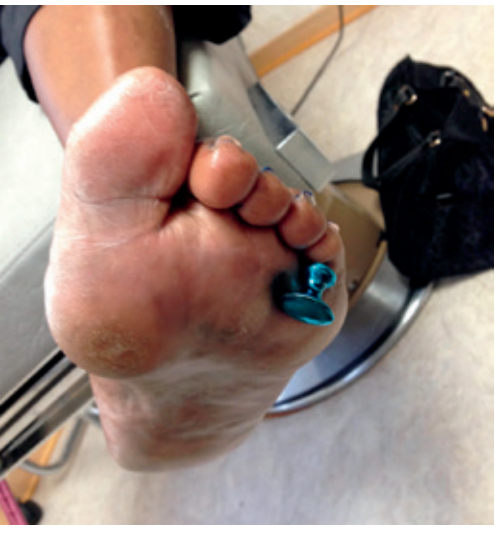
By Jay Meyer, DPM
Podiatry Plus PC, Okemos, MI

According to numerous sources, approximately 10% of the American population is diabetic. The numbers are staggering. Over 30 million who live in the United States have the disease. Millions more are undiagnosed and the senior population has even greater representation at over 25%. Future estimates reveal no let up with an aging population and life expectancies in the upper seventies.

Last year alone, an estimated 120,000 diabetics in the United States suffered a major lower extremity amputation. Each amputation has been estimated to cost almost $175,000 when all the care is calculated. The simple math approaches 21 billion dollars in health care expenditures. The human toll is immeasurable. The major loss of a body part cannot be gaged in heartache alone. Pain, wound care management, the effects on the family, the time needed and the inability to lead a normal mobile life often lead to depression, misery and despair.

Diabetic Foot disease that leads to amputation is usually caused by a combination of either neuropathy or poor circulation. Diabetes causes nerve damage that may lead to significant sensory neuropathy. The effects may even impact the circulation. When a diabetic loses the ability to feel, their feet are unprotected. If the patient is overweight or unreliable, they may not even know their feet are at risk. The patient may step on a sharp object, wear a shoe that doesn't fit, have severe corns and calluses that they neglect, or have a foot deformity that gets constantly irritated. Simply put, the patient may accidently hurt their foot and never know! Once a wound or ulcer forms, the door is wide open to infection where limb loss becomes a significant probability.

Once a diabetic ulceration is established, it can worsen into cellulitis, infect bone, cause sepsis, or become gangrenous. Ulcers may persist for years and require treatment to prevent or control spread. It has been estimated that the 5 year survival rate following a below knee amputation is the third leading cause of death in the United States closely behind Pancreatic and Lung Cancer.



Podiatrists are keenly aware of the complications associated with diabetic foot disease. They are the only health care professionals uniquely trained to manage the challenging nature of the disease. In fact, numerous studies have pointed out the potential of a 95% reduction in the complication rate for those diabetics under the care of a podiatrist. Common sense solutions include: simply wearing shoes that fit, avoiding barefoot walking, regular debridement of thickened nails and calluses, and the early surgical management of pressure points that prevent the development of ulceration. It sounds simple, but it works, if the patient is reliable and an active partner in his or her own care.

Podiatrists bear witness to the despair of Diabetic foot disease. An elderly female steps on a rusty sewing needle or a thumb tack while walking barefoot and does not seek help immediately because they cannot feel. A middle-aged gentleman walks into the office with dirty feet and shoes that have worn to the ground because they have lost all their tread. These and thousands more present every day to podiatrist offices all over the country with preventable disease. The amputations and human suffering does not have to be the norm. Thankfully, more primary care providers have recognized the importance of Podiatric Medicine in a team approach in the overall management of Diabetes. The results speak for themselves; a massive reduction in the human and financial costs of a very chronic and deadly disease.

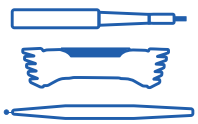
Take the guesswork out of diagnostics

Customized pathology services for better patient care

Diagnostic Services

Therapeutic Solutions

Biopsy Instruments



Learning Center

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Feet are the foundation to good health

By Katherine E. Pratt, B.S., D.P.M.
Podiatry Associates of Charleston, LLC

There are five major issues that usually prompt a person to visit their podiatrist; nail changes, foot shape changes, skin issues, pain, and injury. Usually these problems are minor inconveniences in our daily lives and are easily addressed. Sometimes, however, they are something else entirely.

Feet are the foundation on which we stand and can tell us important information about our overall health. Many serious systemic conditions manifest as problems that can appear in the feet. Vigilance is the key to identifying a potential problem right as it starts and taking appropriate action to negate its effects.

As we age, diminished flexibility, eyesight, and hand strength can often make routine foot care and inspection more difficult for a person to do on their own. That is why it is important to establish a relationship with your podiatrist and to be seen on a regular basis.

While the majority of the time a person spends with their podiatrist focuses on care of the feet, there are multiple subtle clues about the patient's overall health that the doctor is detecting at the same time. Even a simple conversation about your recent vacation, a glance at your shoes, or walking with you to the reception desk, tells your doctor countless things about not only your feet, but your entire constitution.

Listed below are the five major foot issues along with just a few examples of other conditions to which your feet might be alerting you.

Nail changes

Over time, it is normal to have some thickening and brittleness in your nails. However, significant changes such as discoloration, flaking, and an irregular surface appearance can signify a problem. Nail fungus (Onychomycosis) is a very common issue and can be treated with several modalities including topical or oral medications, nail removals, or laser pulses. In addition to direct injury, certain systemic conditions can manifest as changes in the nails. Psoriasis, bowel disease, heart disease, anemia, blood disorders, immune disease, thyroid issues, autoimmune disease, malignancies, and connective tissue disease are just a few examples.

Foot shape changes

As the years go by, it is common to see changes in the shape and support system of the feet. Ligaments and tendons can loosen or fail to function properly leading to problems such as a lowering of the arch, tightening of the joints, and deviation of the digits. Bunions and bent toes can have multiple causes. Some of these conditions are congenital (from birth) and can worsen over time. Trauma to the feet, even if it was in our

youth, can manifest as misalignments in the foot. Certain systemic conditions such as osteoarthritis, rheumatoid arthritis, psoriatic arthritis, and connective tissue disease can also cause changes in the appearance of the foot.

Skin Issues

Itching, redness, cracking, odor, and dry skin are typical issues that bring a patient to their podiatrist. Usually these problems are easily treated with medications. However, sometimes the underlying cause can be something more significant than just the outward symptoms. Skin changes seen in the feet can be from systemic conditions such as eczema, psoriasis, drug interactions, connective tissue disease, autoimmune disease, bacterial or viral infection, arthritis, and many others. In addition, swelling that can appear in the feet can be from vascular issues, heart disease, injury, or positional limitations.

Pain

There are many different causes and types of pain that affect the foot. The pain may be mild to severe, acute or chronic, and can be from either a foot or systemic issue. Toenails that are too long or thick or incurved can cause significant pain and limit a patient's activity and choice of shoe gear. Poor circulation can lead to a sharp stabbing ischemic pain in the feet and toes. Neuropathy from systemic conditions such as diabetes mellitus, palsy, and nerve disease and can produce a sensation of burning, tingling, and numbness all at the same time. Bone and joint pain can be caused by arthritic conditions, injuries, and ill fitting shoe gear. Direct injuries to the feet can cause as many types of pain as there are types of trauma.

Injury

Our feet are abused on a daily basis. Overuse is a common cause of many foot issues and can lead to a significant number of problems later. Stress fractures and muscle or ligament strain can be debilitating. Open wounds, cuts, insect bites and the associated infections that can arise may cause major complications if they are not addressed rapidly and properly. Fractures to the feet can be simple such as a broken bone in the smallest toe to a compound fracture of the calcaneus. Both injuries are painful and limit a person's activities but they are treated quite differently.

AMERICAN SOCIETY PODIATRIC MEDICAL ASSISTANTS

INVOICE FOR ASPMA MEMBERSHIP RENEWAL

$90.00 NOW DUE

It is time to renew your ASPMA membership dues for 2019. Payment is due December 31, 2018
Please complete this form in full. ASPMA is a related organization of APMA and our bylaws state that all memberships must be verified. Your doctor MUST be a member in good standing for you to continue your membership in ASPMA. (Forms submitted without the required information will be returned unprocessed.)

Upon receipt of your renewal form, you will be issued two stickers for 2019. Place one on your membership card and one on your name badge. If you are a PMAC, your membership will be verified before you can begin your annual recertification process.

PLEASE NOTE MAILING PREFERENCE

RENEWAL FORM (Please print legibly)

Your Name: _____

Your DPM Employer: _____

Office Name: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

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ASPMA Membership Chair
602 Bradley Dr. Apt A
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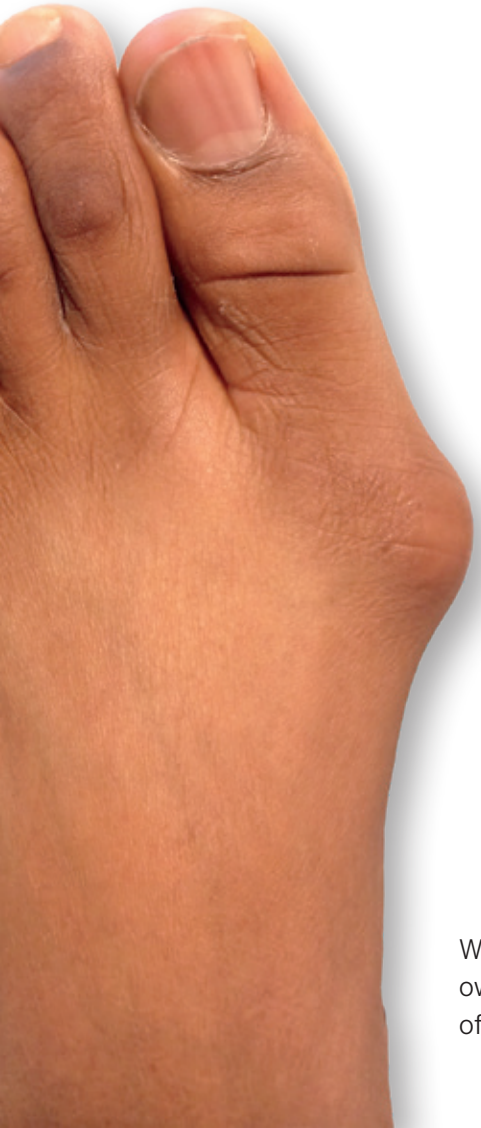
What is a bunion?

By Kim Heineman, PMAC

A bunion is one of the most common problems with the first toe. Your first toe supports most of your body weight every time your foot pushes off the ground when walking. Therefore, any problems can make walking or standing painful. A bunion is a misaligned bone in the joint or an excess of bone. There are different types and severity of bunions. Therefore, there are many ways to treat or correct a bunion.

Some bunions may be treated conservatively with orthotics to control foot function or with pads or changes in shoe gear to relieve discomfort. If a bunion is painful or severe, surgery may be recommended. There are multiple procedures to correct a bunion deformity that include the shifting of soft tissue, the shifting of bone or the removal of bone. Procedures can include one or all of these.

Some common bunion procedures are as follows:



1.) **Austin Bunionectomy:** This is a common procedure to correct a bunion deformity. Part of the procedure includes removing the excess bone from the side of the 1st metatarsal head. A second part to the procedure involves making a V shaped cut in the bone just below the metatarsal head, or an osteotomy, to reposition the bone closer to the 2nd toe to reduce the angle of the bunion deformity. Screws or some type of internal fixation are generally used to hold the bone in place.

2.) **Lapidus Bunionectomy:** This is a bunion procedure used to correct a moderate to severe bunion. This procedure involves removing a small wedge of bone at the base of the 1st metatarsal to reduce the bunion deformity. The base of the 1st metatarsal is then fixated with plates and screws to the medial cuneiform. This will cause the joint between the 1st metatarsal and cuneiform to fuse, therefore preventing the return of a bunion.

3.) **Keller Bunionectomy:** This is a simple procedure used to alleviate severe arthritis pain. In a Keller procedure, there is removal of the cartilage surface and a portion of the proximal phalanx. This changes the metatarsal-phalangeal joint relieving pain due to arthritis in patients whose condition or factors such as age or mobility may prohibit a different or more complex procedure.

4.) **Silver Bunionectomy:** This is a procedure for patients who do not have any associated angular deformity with the 1st metatarsal. It generally involves removing the bony growth, or exostosis, that builds up along the 1st MPJ due to rubbing and pressure.

5.) **McBride Bunionectomy:** The McBride procedure includes the removal of the exostosis like the Silver procedure, but also includes soft tissue release or reconstruction to help with the angular deformity of the bunion.

While there are many surgeries to correct a bunion deformity, each podiatrist has their own opinion on procedures and will evaluate each patient to determine the best course of action.

Most Effective Ways to Market Your Practice

By Tara Brown, PMAC
Vice-President, ASPMA

No matter if your practice has been in business for years or just started marketing will always be a part of the practice. Marketing is one of the things everyone who owns or manages a business stress about. We never know if the money we are investing into marketing is going to work. It is one of things that we put hundreds of dollars in and don't see a return until six months to a year later.

Over the years I have tired multiple ways to market the practice. Here are some effective ways I have seen work to ensure that you see patients walking into your practice:

1. **Place an AD -** To some this may be the old school way but it's one of the most effective. You'll be surprised how many people still pick up a newspaper or magazine every day to read. If your ad is placed each time the newspaper or magazine is released the image and words will get embedded into the person memory. So, make sure that ad is MEMORABLE!

2. **Social Media -** It is no secret that the time we live in is becoming more and more technology based and social media is KING. If your practice wants to gear more to the millennials then you best bet is to market on social media. Some sites that are great to promote on are Facebook, Instagram, Twitter, Pinterest, YouTube just to name a few. Try one or two of them out and see works best.

3. **Get out in the community -** What better way to get to know the people that live and work in the area you practice. Sign up to get a table at the local health fairs/5k races or sign up to do talks at local senior centers or libraries. While you're there hand out free giveaways from your practice (pens, nail files, calendars, etc.) and talk your practice up. This is a great way to let the personality of the practice shine and show how personable you are.

4. **Networking -** Whoever said, "It isn't what you know. It's who you know" wasn't lying. Networking allows you to connect with other people and business in the area while enjoying a great event. You never know who you could meet and the connections that you make may take you far in your personal and professional life.

Marketing is a gamble, you may see success and sometimes you may crap out. Just remember if you don't see any good results within three to six months let it go and try something else out, don't get discourage.

Happy Marketing!

Podiatric Fracture Management: A Systematic Approach

CONSERVATIVE VERSUS SURGICAL TREATMENT

Bryan Camp DPM[1]
David Smith DPM[1]
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Introduction

The foot and ankle complex are an efficient and powerful physiologic machine, which over the years is expected to undertake and survive an incredible amount of force. The biomechanics structure of the lower extremity is designed to function by absorbing the stresses placed upon it, while ideally remaining pain and injury free. It can be expected however, and what we commonly see, is that there is sometimes a breakdown in the body's force-absorbing mechanisms. This can occur for several reasons including but not limited to: an external force applied is greater than the body's ability to withstand that force, a normal force is applied to an abnormally aligned foot and ankle, or possibly other medical conditions predisposing to fracture.

This paper is designed to look at fractures of the foot and ankle. We will discuss different fracture patterns, mechanisms of injury, as well as the appropriate treatment recommended based on fracture type and severity.

WHY DO BONES BREAK?

When normal lower extremity biomechanics are employed, and all bones and joints are in their proper and physiologic alignment, and when no excessive external forces are placed on the foot, then the chance of injury remains low. However, if there happens to be abnormal alignment, or if a force exceeds the strength of the bone it is applied to, then injury occurs. Pressure is equal to the force divided by the surface area, so a large force applied to a small surface area exerts a higher pressure per square unit. A simplistic example is the pressure exerted from a female standing on the ground while wearing tennis shoes versus wearing a high heeled shoe. The force is spread out over a larger surface area with a tennis shoe, so the pressure is less than the pressure exerted by a high heeled shoe, due to its much smaller surface area.

FRACTURE PATTERNS

The pattern in which a bone breaks depends on many factors. For simplicity, a bone breaks depending on the orientation and motion of the foot at the time an external force is placed upon it. For example, the Lauge-Hansen classification for ankle fractures defines all fractures of the fibula and tibia based on the position of the foot at impact, and also the direction of motion at impact[1]. Thus, we have a relatively simple classification system that tells us the mechanism of the fracture, but more importantly, how we treat it.

Typical fracture patterns seen are:

- Transverse (fig 1a)
- Greenstick (fig 1b)
- Spiral (fig 1c)
- Oblique (fig 1d)
- Comminuted (fig 1e)
- Stress (fig 1g)

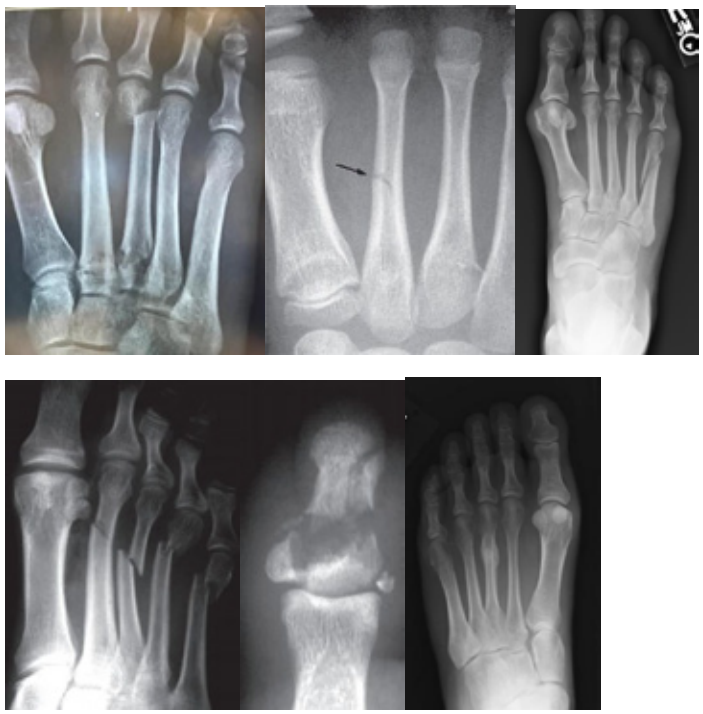

Fig 1. A. Transverse fracture of the 3rd metatarsal with displacement and rotation. B. Greesntick fracture of second metatarsal with preservation of the lateral cortex[2]. C. Spiral fracture of the 5th metatarsal shaft with displacement and shortening. D. oblique fractures of the 2nd and 3rd metatarsals, with transverse fractures of the 4th and 5th metatarsals, all fractures being displaced laterally[2]. E. Comminuted fracture of a distal phalanx[2]. F. Stress fracture of the 3rd metatarsal which is showing signs of healing with bony callus present[2].

PHYSIOLOGY OF BONE HEALING

It has been well-studied and well-documented that, in a normal healthy individual with no metabolic or autoimmune disorders that would slow healing, bone takes approximately 6-8 weeks to heal[3,4]. This means that when a fracture occurs, there is a well-defined period of time that the bone needs to be free of stress, strain, and deforming forces in order for healing to take place. Herein lies one of the inherent difficulties of podiatric surgery- it is especially problematic for a patient to remain off the affected extremity for up to two months. We will discuss later the two general ways to treat fractures: conservatively or surgically, and we will discuss indications for both avenues of treatment.

Bone is a composite of organic and mineral components. The organic component of bone primarily consists of type 1 collagen, which provides tensile strength. The mineral component is organized into a compound called hydroxyapatite which gives the stiffness and rigidity characteristic of bone. Bone healing is typically divided into three overlapping stages: inflammatory, reparative, and remodeling. Time frames for each phase vary due to healing rates according to age and comorbidities. The inflammatory stage is initiated with hematoma formation around the fracture site and macrophages invade the area to remove dead bone and tissue. In the reparative phase, new blood vessels develop from outside the bone to supply nutrients. Callus formation occurs as endochondral bone forms around the fractured area. In the remodeling phase, the endochondral bone becomes completely ossified and the bone undergoes structural remodeling. Factors that affect the rate of bone remodeling include age, tobacco use, excessive chronic alcohol use, and nutritional status. Common conditions that impair fracture healing include diabetes mellitus, vascular disease, anemia, hypothyroidism, and malnutrition[3,4].

CONSERVATIVE FRACTURE MANAGEMENT

Any time a patient undergoes a surgical procedure, it has the potential to be life-altering. Even seemingly innocuous procedures still require time off work, family obligations are compromised, and finances are an ever-present issue. This is not to say that the physician should base their treatment off the patient's personal and financial situation, but it is a factor to consider when deciding upon the appropriate treatment plan.

We will first discuss conservative treatment for fractures, but to better understand which fractures candidates for conservative management are, we'll list the surgical

indications. Surgical indications include but are not limited to: displacement of greater than 2mm, neurovascular compromise, open fractures, gross instability, and intraarticular fractures. Other fractures which do not meet these criteria can be treated conservatively.

Prior to initiating treatment, either surgical or conservative, it is essential to order plain film radiographs at a minimum. This allows us to evaluate the bones for alignment and possible fracture. Certain injury patterns may require additional advanced imaging. For example, fractures of the calcaneus or Lisfranc's joint oftentimes require CT for detailed fracture pattern analysis and surgical planning5. After the imaging results are interpreted both by the ordering physician and the radiologist, and the patient is appropriately evaluated by the podiatric physician, at this point a determination can be made for either conservative or surgical management.

As was mentioned earlier, bone takes between 6 and 8 weeks to heal. Healing occurs when there is anatomic alignment and compression with a lack of motion at the fracture site6. This means that a non-displaced fracture in a weight-bearing bone needs to be immobilized to allow for healing to occur. There are many modalities available to accomplish this. Application of a below knee cast, splint, or CAM boot assist with remaining either non-weight bearing or partial weight bearing. Also, at the physician's and patient's disposal is traditional underarm crutches, knee scooters, or even a wheelchair if the individual circumstance dictates. Utilizing any of these modalities does not ensure that the patient will not walk on it; it is far too common to see noncompliance even with a cast on, but what it does is help to maintain stability while providing a reminder to the patient that they have an injury and they need to be mindful of it.

Each podiatric physician has an individualized protocol for managing fractures conservatively. This usually consists of serial imaging, pain control, weight bearing status, and patient functional ability. Baseline x-rays with follow up films at weekly, bi-weekly, or monthly intervals are often ordered. On x-ray, what we look for is bony bridging across the fracture site, and to ensure that the fracture does not displace. Pain medication can be prescribed at the physician's discretion, but prescription pain medication is rarely needed much after the initial injury occurs. If pain persists, then over the counter pain medication can be used. However, there is some debate on whether NSAIDs should be used in the setting of an acute fracture[7,8].

The patient will be slowly transitioned from their splint/cast and into something which will allow for more weight-bearing or range of motion when the physician sees fit. Continued follow up takes place until the physician feels comfortable letting the patient back to normal activity.

SURGICAL FRACTURE MANAGEMENT

As was mentioned earlier, when a fracture is suspected, it is imperative to order plain film radiographs at a minimum. As a podiatric surgeon, we should be proficient at reading plain film x-rays, but a radiologist's interpretation is valuable in evaluating and understanding the patient's unique injury.

As was mentioned earlier fractures that are displaced, open, or unstable generally need surgical fixation. Internal fixation using plates and screws is a common and reliable way to fixate fractures. Proper AO technique aids in bone healing, proper union of fracture fragments, and long-term patient satisfaction[6]. There are many different approaches and techniques to reducing a fracture, all of which are at the disposal of the physician according to his or her skill and training.

After surgery, the patient is kept in a dry sterile dressing and boot/splint for a period of non-weight bearing dictated by the surgeon. As was discussed with conservative treatment, the patient will be closely monitored by the surgeon in the postoperative period. Since bone takes between 6-8 weeks to heal, close follow up lasts at least this long. As a general rule, the patient is to keep the operative site dry until sutures come out (usually at 2-3 weeks). After this time, non-weight bearing is maintained for a few more weeks. The patient is then gradually allowed to bear weight as tolerated with a slow return to activity. As was discussed earlier, serial x-rays are utilized to ensure proper alignment and bony bridging, oftentimes done at 1,3, and 6-week intervals.

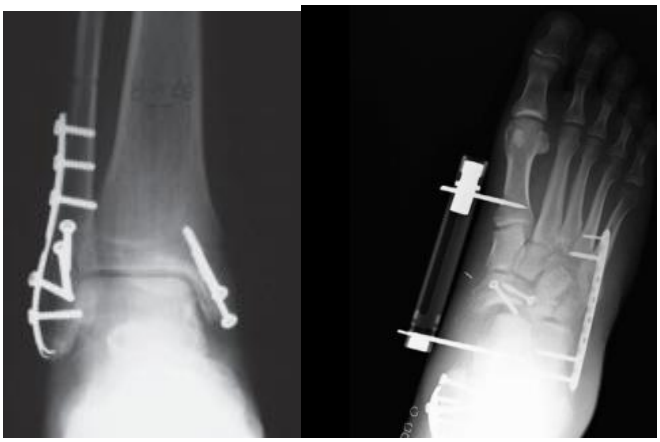

Fig 2. (A) Ankle fracture internal fixation consisting of medial malleolar screws and a fibular plate with compression screws. (B) Injury fixated with a combination of internal fixation and external fixation[2].

Fractures in children and adolescents have unique considerations. Children's bones react much more quickly to fractures than those in adults. Within days, callus joins the fracture fragments together. The periosteum in children is substantially thicker and more robust than in adults, accounting in part for the more rapid healing of pediatric fractures9. Due to this quick timeframe, reduction of the fracture is easiest with the first 24 hours. In general, closed reduction is preferential for adolescent's fractures. The healing capacity of growing bone is considerable. Pseudarthrosis seldomly occurs and malunion may be corrected by subsequent growth. The goals of fracture treatment in children is prevention of malunion and growth disturbances. Operative treatment should be considered when closed reduction fails or when surgery will predictably prevent a poor outcome.

Another commonly seen fracture is a stress fracture. These injuries develop after the adage, "too much, too fast, too soon." These are usually seen with patients who have recently started a new exercise program, or a new physically laborious job, or have simply increased their activity too quickly without allowing their bones to respond to the increased stress. A common example is someone who has decided to run a marathon and increased their mileage significantly. After a few weeks of training they start to develop pain in their foot, commonly the midfoot over the metatarsal bones. Clinically we see a red and swollen area corresponding to their pain. Radiographically, it can be difficult to diagnose stress fractures on plain film x-rays early on, but cortical irregularities at the site of the patient's pain combined with a detailed history of overuse can lead to a diagnosis of a stress fracture. Treatment of a stress fracture consists of temporary cessation of the activity and immobilization in a CAM boot or post-operative shoe for a few weeks to allow for bony healing to commence.

CONCLUSION

Throughout the course of one's lifetime a person might walk upwards of 100,000 miles10. It is amazing how durable the foot can be. Perhaps even more amazing though, is that when an injury does occur, such as a fracture, the body is capable of healing a bone back to its normal strength. There are many variables that play a role in the healing of a fracture. The podiatric physician's role is to understand the specific fracture so that the appropriate treatment can be initiated to allow for the patient's own body to heal. It is critical for physicians to know when a patient needs conservative management, or when a trip to the operating room is necessary. Successful outcomes and satisfied patients can be achieved with both routes of treatment.

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ADMINISTRATION EXAM REGISTRATION FORM/STUDY GUIDE

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The American Society of Podiatric Medical Assistants

Is pleased to announce the offering of a full day review course and clinical examination for **Podiatric Medical Assistant, Certified**

The review course will be offered on **Friday, October 19, 2018**
Exam next day **Saturday, October 20, 2018**

Both will be held at:

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*****This exam contains the radiology requirements for Indiana assistants taking x-rays.*****

EARLY REGISTRATION FEE:

$325.00 which includes the Exam Fee and the Comprehensive Study Guide to Podiatric Medical Assisting, 5th Edition Please allow 10 business days for shipping of the study guide.

Exam fee $375.00 after September 20, 2018 includes The Comprehensive Study Guide to Podiatric Medical Assisting, 5th Edition due to the date of your registration you might not receive the study guide before the exam date.

Deadline to register for the exam is **October 12, 2018**

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ASPMA Membership Number _____

Doctor name _____

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FOR FURTHER INFORMATION, CONTACT THE ASPMA BUSINESS OFFICE AT 888-88-ASPMA

Assistants Tracks 9

Assistants Track 1: Administrative

Program Schedule

Friday, November 9 and Saturday, November 10
Friday Registration: 8:00 a.m. – 9:00 a.m.
Friday Lectures: 9:00 a.m. – 4:30 p.m.
Saturday Lectures: 9:00 a.m. – 1:30 p.m.
LUNCHES INCLUDED

Friday Topics*

Featuring — PPMAA Annual Luncheon & Basket Raffle
Wound Care
Recognition and Diagnosis of Vascular Disease in the Lower Extremities
Risk Management for the Podiatric Medical Assistant
Skin Disorders and Diseases

Saturday Topics*

Overview of the Diabetic Foot
Effective Medicine Reconciliation
Pearls for Post-Op Podiatry Management

**Subject to Change Without Notice*

Track I Attendees Must Register with the Goldfarb Foundation to attend the course. Registration with the Foundation can be done either at www.goldfarbfoundation.org or use form on page 10. For questions about Track 1, contact Paula Stout, RTR, ARRT, PMAC, current PPMAA President, at pstout@atlanticbb.net or call 814-226-0717.

Assistants Track 2: ASPMA Exam

PLEASE NOTE: Assistants MUST BE a member of ASPMA prior to registering for the exam. For questions about Track 2, contact Elizabeth Rudy, PMAC, at 504-450-0243 or bethpmac@aol.com.

Program Schedule

Friday, November 9 —
ASPMA Clinical Review Course
8:00 a.m. – 5:00 p.m.

Saturday, November 10—
ASPMA Clinical Certification Exam

- 8:00 a.m. – 11:00 a.m.
- After 11:00 a.m. – grading on-site
- Join Administrative Track 1 at the conclusion of the exam

Exam Categories Covered:

- Anatomy/Biomechanics
- Clinical Testing and Procedures
- General Information/Knowledge of Podiatry/ Administrative Responsibilities
- Medical Emergencies and CPR
- Radiology
- Surgical Assisting & Instrumentation
- Terminology

Clinical Exam Study Kit Order Form – $150 each when buying separately
Go to: http://tinyurl.com/ASPMAStudyGuideForm

1) Track II Attendees Must Register with the Goldfarb Foundation to attend the course and lectures.
2) Track II Attendees Must also Register Separately with ASPMA to take the ASPMA Exam.

Both forms are on page 29.

10 Assistants Tracks 1 & 2/Office Staff Goldfarb Foundation Registration Form

First Name*_____Last Name*_____Title*_____

Address #1*_____ Address #2*_____

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Phone*_____Fax*_____Email*# _____

** Required Information*

#A valid email address is required to receive your confirmation email.

Track 1: Administrative Program

❍ PPMAA Members $160*
❍ Non-PPMAA Members $185

Track 2: ASPMA Review & Exam Program:

TRACK 2 MUST ALSO complete the separate exam registration form at bottom of this page.

❍ PPMAA Members $160*
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APMA CODING SEMINAR

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Assistants Track 2 - Exam Registration Form

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PHONE: 1-888-882-7762
Or FAX with credit card information and signature to 847-773-9976

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Doctor's Name/Practice*_____

Address*_____

City*_____ State*_____ Zip*_____

** Required Information*

Phone, Fax, Email*_____

CHECK: Payable to ASPMA Qualifying and Examining. A $25 fee will be charged for all returned checks.

CREDIT CARD TYPE: _____ (MC, VISA, AMEX , & DISCOVER accepted) CVV Code_____

ACCOUNT #_____ Exp. Date_____Billing Zip Code_____

ASPMA Website: www.aspma.org. For questions about the ASPMA Exam, contact Elizabeth Rudy, PMAC, at 504-450-0243 or bethpmac@aol.com

THIRD QUARTER

2018 JOURNAL QUESTIONNAIRE

(Equinus)

1. _____ a condition in which the upward bending motion of the ankle is _____.
2. People with equinus always find a way to _____ for their limited ankle motion.
3. The _____ gait cycles require the ankle to_____.
4. Equinus is associated with so man_____.
5. Most people with equinus are _____ that they have it.
6. Equinus can be in _____ or _____ feet.
7. _____ devices can be helpful when _____ equinus.
8. If stretching is not successful _____ is the last resort.
9. _____ equinus is related to a bone blocking the ankle motion.
10. To _____ equinus the foot and ankle surgeon will _____ the ankle range of motion.
11. Equinus may be_____ or _____.
12. Equinus is found _____ in men and women.
13. The _____ of _____ _____ _____ is another name for equinus.
14. _____ are placed in the shoes to help relieve stress from the Achilles tendon.
15. Some patients compensate by _____ _____.
16. Equinus is a _____in many foot and ankle conditions.
17. _____ or _____is used to measure the degree of dorsiflexion.
18. I extend pass the knee and I am worn 1 hour per day _____ _____.
19. True or false- plantar fasciitis is related to equinus.
20. True or false- you can be born with equinus.
21. An_____ _____ _____ can be used for the patient suffering from equinus with an element of drop foot.
22. True or false- The person with ankle equinus has the tendency to walk on the ball of the foot.
23. True or false- flat feet is the only cause related to equinus.
24. True or false- low back pain is not associated with equinus.
25. _____ _____ is worn at night to keep the foot aligned and help reduce the tension in the calf muscle.
26. True or false- physical therapy can be used to help with equinus deformity.
27. _____ exercises are used to help relieve calf muscle tightness.
28. True or false- calf cramping is associated with equinus deformity.
29. True or false- bunions are not related to equinus deformity.
30. True or false- equinus is the only cause of arthritis in the mid foot.

Podiatry Radiography

The following will apply for CME credit for the 2018-2019 recertification year. All completed answer sheet should be mailed with your recertification in April of 2018. At that time attach all Journal answer sheets to your notice and mail them to the address listed by your state.

1. What is the annual maximum permissible does for an occupational worker (x-ray tech)?
   a. 100 mrem/year
   b. 10 rems/year
   c. 50,000 rem/year
   d. 5 rems/year

2. Which type of radiation is deflected from its original path when it strickes an object?
   a. Ionizing radiation
   b. Primary beam radiation
   c. Scatter Radiation
   d. Nuclear Radiation

3. Which factor controls the amount of radiation emitted from the x-ray tube?
   a. kVP
   b. mA
   c. time
   d. SID

4. Resolution, Definition and sharpness of an image are all components of:
   a. Distortion
   b. Motion
   c. Detail
   d. Magnification

5. A Podiatric X-ray Unit must be licensed and registered, and the actual certificate must be displayed for anyone to view?
   a. True
   b. False

6. Which of the following is NOT an example of "subject contrast"
   a. Bone and soft tissue
   b. Bone and air
   c. Bone and calcium
   d. Soft tissue and air

7. The distance from where photons are emitted to the film is called?
   a. Object-image distance
   b. Source-image distance
   c. Object-Anode distance
   d. Source-Anode distance

8. Electrons are found in what part of the Atom?
   a. Nucleus
   b. Inner Shell
   c. Outer Shell
   d. Protons

9. C-Arm fluoroscopy units utilize which process to create an image?
   a. X-ray beam and image intensifiers
   b. X-ray beam and film screen cassettes
   c. Sound waves and recording device
   d. Sound waves and transducer

10. A Mortise View is used to evaluate a/an _____
    a. Sesamoid fracture
    b. Jones fracture
    c. Ankle joint
    d. Metatarsal Fracture

11. Your doctor has told you there is a radiopaque foreign body on the film. It is not in the area of interest on the current patient, but he had noted ti was obscuring the area of interest on the prior patient. What do you do?
    a. Keep exposing the patient until the radiopaque object disappears
    b. Clean the cassette screens first, then retake the film
    c. Clean the processor crossover racks, then retake the film
    d. As long as it is not on the area of interest leave it alone.

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