THE NATIONAL TODAY

OFFICIAL NEWSPAPER OF THE APMA ANNUAL SCIENTIFIC MEETING

FRIDAY, JULY 24, 2015
Orlando World Center Marriott

For additional meeting coverage, visit www.apma.org/thenational

TODAY'S SCHEDULE

5:30–6:30 a.m.
WERQ® Fitness Class
Miami

6:30–8 a.m.
Breakfast Symposium: Vascular Evaluation of the Preoperative Patient and Review of Vascular Complications (Risk Management Program)
Royal Ballroom

8–9 a.m.
Plenary Lecture: Acral Lentiginous Melanoma: What Sets it Apart?
Sago Ballroom

8–9 a.m.
PFA Annual Symposium: Adolescent Pathology
Crystal J1-KL

8 a.m.–12:30 p.m.
ASPMA Certification Examinations
New Orleans (Administrative)/New York (Clinical)

9–9:30 a.m.
Exhibit Hall Break and CECH Scanning Break (DPMs and assistants)
Cypress Exhibit Hall

9–10 a.m.
Exhibit Hall Break (pedorthists)
Cypress Exhibit Hall

9:30–11:30 a.m.
Track 3: Residency Directors' Workshop
Crystal J2-M

9:30 a.m.–12:30 p.m.
Track 1: Oral Abstract and Evidence-Based Medicine Presentations
Crystal G1-AB

9:30 a.m.–12:30 p.m.
Track 2: Radiology
Sago Ballroom

10 a.m.–12 p.m.
PFA Annual Symposium: Podiatric Medical Treatment
Crystal J1-KL

SEE SCHEDULE, PAGE 3

Patriotism, Parity in the Spotlight

Lieutenant Commander Kittra Owens, DPM: "I was in a country where women didn't have a voice, where a woman didn't dare tell a man how to do a job. But that was my assignment."

Thursday's opening session brought hundreds of attendees to hear the story of one podiatrist and her astounding experience in the US military. Lieutenant Commander Kittra Owens, DPM, who retired from active duty in the US Navy in June, shared her experience and asked members of her podiatry family to advocate for podiatrists still serving on active duty or in the Veterans Health Administration (VA).

When a Navy recruiter contacted Dr. Owens shortly before the end of her residency, she had doubts. After all, a military life would mean frequent relocation, less pay than in the private sector, and fewer opportunities for promotion. But it also would mean paid expenses, great benefits, an option for student loan repayment, and a waiting pool of patients. "I felt like the experience would be priceless, so I was commissioned into the Navy," she said.

Eight years later, Dr. Owens has practiced medicine in six countries. "Through every mission, I've redefined myself and diversified my practice."

When she received orders to deploy to Afghanistan, she was particularly proud. The Navy typically used orthopedic surgeons in such settings, because the allopathic physicians can cover more anatomical ground. Dr. Owens didn't know the nature of her assignment, but spent months preparing with weapons training and instruction in Dari, the local language.

Dr. Owens' mission was to instruct seven Afghan National Army orthopedic surgeons in lower extremity care so they would be prepared for the planned withdrawal of NATO. She was stationed in eastern Afghanistan on the Pakistan border in a very dangerous area. Conditions were harsh, and the surgical team lacked basic operating procedures, as well as sterile supplies and medications.

SEE OPENING SESSION, PAGE 10

Osteopathic Manipulation Useful in Treating Lower Extremities

Doris B. Newman, DO

The advantages of using osteopathic manipulative treatment (OMT) to align the joints of podiatric patients and improve their flexibility were discussed and demonstrated Thursday during "Osteopathic Manipulative Treatment of Lower Extremity Disorders."

"We want to demonstrate some of the hands-on manipulation techniques that I use every day with my patients," said Doris B. Newman, DO, president of the American Academy of Osteopathy (AAO). "We look at feet and lower extremity alignment because of their importance to back health, spine health, neck health, and the underlying health of the whole person.

"We look at the central nervous system and the interrelatedness between the central nervous system and the visceral system for the health of the patient and in improving the axoplasmic nerve conduction flow as well as the arterial blood flow to all of the organs and somatic structures, including the extremities."

The American Academy of Osteopathy is an affiliate of the American Osteopathic Association, which would like to work with APMA to expand options for the treatment of podiatric patients, Dr. Newman said. She used the session to discuss the advantages of OMT techniques to improve mobility and alignment, and to

SEE MANIPULATION, PAGE 3

APMA American Podiatric Medical Association

INSIDE

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MANIPULATION

CONTINUED FROM PAGE 1

invite podiatric physicians to learn more about manipulation.

"The codes for manipulation are not owned by osteopaths," she said. "Anybody can learn. AAO has many continuing medical education classes, and we allow other professions to belong to our organization. Osteopathic manipulation techniques can be used to treat just the feet if you are not going to treat above that, and still do a lot of good."

OMT can be used to improve blood flow to the lower extremities, Dr. Newman said. It also can be used to improve range of motion in joints that often are abused and can cause feet to be compressed.

"Feet are some of the most important parts of the patient to diagnose, to treat, and to get moving," Dr. Newman said. "It is very important to have those joints aligned as well as possible, particularly if you are going to use something like an orthosis.

"I always evaluate feet. I always do gait analysis because you pick up so much asymmetry from it. I always check foot mobility. I am excited when patients go from flat, hard, immobile feet to having some foot motion."

The AAO has an associate member category for podiatric physicians who are interested in learning more about OMT to help patients while earning continuing medical education credits.

"This is a fledgling opportunity, and we want to reach out to fly the flag of osteopathic medicine and manipulation," Dr. Newman said. "We want to help people understand how it can be used for their patients. We want podiatrists to understand more about if they want to refer someone to an osteopathic manipulation specialist or a DO who does OMT. Additionally, there are opportunities for podiatrists who want to learn more about OMT." ○

Question of the Day

Q: *"What Do You Think About Using Osteopathic Manipulation?"*

Adriana Karpati, DPM
Southlake, TX
"I thought it was fascinating that there were some techniques I have not seen before. I question our abilities to fully implement those in our current practice without needing some extensive training."

David Alan Edmonds, DPM
Macungie, PA
"I learned this in podiatry school, and so this was a good refresher. I am comfortable doing this, and I plan to use it in my practice."

Raymond P. Rowan, DPM
Davie, FL
"I would like to know more about it. It is interesting, but I am not sure how thorough of an evaluation she does before she starts."

Donna M. Alfieri, DPM
Freehold, NJ
"I think this is very interesting, but I don't feel comfortable doing it myself. I think it is something that would lend it self to more teaching. I think a workshop on this would be a good idea."

Jim Ricketti, DPM
Hamilton Square, NJ
"I learned a few techniques I will take back to the office. I am comfortable doing this."

John M. Diehl, DPM
Concord, NC
"It is a great tool that could be used, but we need to get the proper training to do it and not cause more harm than good. I would like to learn more about this, but I need to find out where to go to do that because I do think it can play a role. It can give us another tool to treat our patients, but I do feel you have to be trained so you are not causing harm, just as we have to be trained in surgery."

Tinea Pedis Update: Production of Protein Key in Control

New research shows that the protein dermcidin could play a key role in controlling athlete's foot, Bryan C. Markinson, DPM, reported Thursday in his Plenary Lecture, "Tinea Pedis Update."

"The body secretes dermcidin, which is toxic to fungi. The inability to produce this may trigger more infections," said Dr. Markinson, who added that researchers are investigating methods to supplement the production of dermcidin. He is the chief of podiatric medicine and surgery at the Leni and Peter W. May Department of Orthopedic Surgery at Mount Sinai School of Medicine.

Dr. Markinson discussed advances in research of tinea pedis based on a review of non-podiatric literature published in the last four years. Those advances include the development of new treatments and questions about the effectiveness of laboratory tests in confirming tinea pedis.

Dermcidin is an antimicrobial peptide secreted by eccrine sweat glands. It has been found to inhibit the growth of *T. rubrum, S. aureus, E. coli, E. faecalis,* and *C. albicans,* he said. The most common micro-organisms found to cause tinea pedis are *T. rubrum, T. interdigitale,* and *E. floccosum.*

Other research showed that dermatomycosis infections, such as tinea pedis, are transmitted indirectly in infected scales, hair, nail pieces, the floor, shoe gear and insoles, and clothing. A study reported that microwave irradiation that reached temperatures of 50C–55C destroyed cell membranes and killed fungi in sponge insoles and cork insoles, Dr. Markinson said.

He also reported on the effectiveness of laboratory tests that used positive KOH and positive cultures to confirm the diagnosis of tinea pedis versus a clinical exam.

"Laboratory confirmation studies may not be all they are cracked up be," Dr. Markinson said. "It may be that the gold standard of diagnosis should be what we see with our eyes."

Conventional wisdom holds that a positive fungal culture is required for a definitive diagnosis of tinea pedis. Most studies require a positive culture, positive KOH, and clinical findings. In a pooled study of five similar studies for the diagnosis of tinea pedis, KOH specificity was 42.6 percent versus 77.7 percent for culture. Sensitivity was 73.3 percent for KOH, and 41.7 percent for culture.

"These are important findings for podiatrists because: one, most podiatrists do not do KOH preps; two, in the absence of a positive culture, in view of less sensitivity than KOH prep, and positive clinical findings, clinicians may fail to prescribe antifungal agents; and three, the presence of a negative KOH at screening may allow for earlier consideration of alternative diagnoses." ○

SCHEDULE

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11:30 a.m.–12:30 p.m.
Track 3: ABFAS/ABPM Board Certification Update
Crystal J2-M

12–1 p.m.
Exhibit Hall Break (pedorthists)
Cypress Exhibit Hall

12:30–1 p.m.
Exhibit Hall Break and CECH Scanning (DPMs and assistants)
Cypress Exhibit Hall

12:30–1:30 p.m.
Non-CECH Lunch Symposium: The Use of Grafix in the Treatment of Complex Wounds
Royal Ballroom

12:30–1:30 p.m.
Podiatry Management Hall of Fame Luncheon
Sabal Ballroom

1–5 p.m.
PFA Annual Symposium: Miscellaneous Topics in Pedorthics
Crystal J1-KL

1:30–5:30 p.m.
Workshop 1: Ultrasound
Crystal H

1:30–5:30 p.m.
Young Physicians' Program
Crystal J2-M—Please note room change!

1:30–3:30 p.m.
Small Group Panel Discussion: Session 1: The Podiatric Response to Seropositive Connective Tissue Disorders
Diamond Suite

1:30–5:30 p.m.
Small Group Panel Discussion: Session 2: Dermoscopy for both Melanocytic Skin Cancer and Non-Melanocytic Skin Cancer
Emerald Suite

1:30–5:30 p.m.
Small Group Panel Discussion: Session 3: Comprehensive Equinus Treatment of the Podopediatric Patient (Surgical and Non-Surgical)
New York/New Orleans

3:30 p.m.
CECH Scanning (DPMs)

3:30–5:30 p.m.
Small Group Panel Discussion: Session 1: Achieving Better Outcomes: The Unique Anatomical, Biomechanical, and Hormonal Issues in Female Patients
Diamond Suite

3:30–5:30 p.m.
Small Group Panel Discussion: Session 2: Improving Outcomes with Peripheral Nerve Concepts
Emerald Suite

3:30–5:30 p.m.
Small Group Panel Discussion: Session 3: Florida State Laws and Rules
Sago Ballroom

5 p.m.
CECH Scanning (Pedorthists)

5:30 p.m.
CECH Scanning (DPMs)

Join Team APMA and Help the Future of Podiatry

After a one-year sabbatical, the Team APMA 5K Run/Walk is back at The National and better than ever.

Join Team APMA at 6 a.m. Saturday at the Hawk's Landing Golf Course here at the Orlando World Center Marriott. Once again, the proceeds from the event benefit the APMA Educational Foundation Student Scholarship Fund.

"The spirit of Team APMA is alive and well," said Cary Zinkin, DPM. Dr. Zinkin serves as race director along with Rob Frimmell, DPM. "Dr. Frimmel and I are proud to once again serve as race directors, and although we didn't have an event in Hawaii due to location issues, our 5K remains one of the most popular events of The National!"

This year's location is an important change for the event.

"This year's race will be run at the hotel site," said Dr. Frimmel. "No need to get on a bus to get to our race location. I think this is a huge improvement over previous runs."

To celebrate the return of the event, Dr. Frimmel has decided to increase his donation with a special challenge. He will give an additional donation of $1 for every runner who finishes before he does, and $1 for every runner who finishes after Dr. Zinkin.

As past participants know, there is little else at The National that matches the anticipation for the run to begin.

"There is usually a lot of excitement the morning of the race," said Dr. Frimmel. "We have runners who are very competitive and those who are out there to have fun and walk in support of the cause, the Student Scholarship Fund. There are a few participants who are still sleepy because we start the run early, but it's a great way to get the day started."

> We have runners who are very competitive and those who are out there to have fun and walk in support of the cause, the Student Scholarship Fund.
>
> ROB FRIMMELL, DPM

For Drs. Zinkin and Frimmel, this will be the fifth official Team APMA run. The event has proven to be highly successful.

"Team APMA took off flying immediately after Dr. [Frank] Spinosa presented our idea to the Board of Trustees about six years ago. Since then, we have had well over 100 participants and many sponsors, with all of the proceeds going to the students who need it most," said Dr. Zinkin.

In addition to getting some healthy exercise and contributing to the future of podiatry, race participants enjoy additional benefits.

"The goodie bag is filled with great gifts from our sponsors," said Dr. Frimmel. "It's well worth the entry fee, and it helps such a great cause."

If you have already registered, visit the APMA booth (#923) to pick up your goodie bag. If you haven't registered, come to the APMA booth and sign up! Registration is $20 for students and $25 for everyone else. Do you want to make a donation but are not interested in running? You can register as a "sleeper" and receive a comfy T-shirt while staying in bed Saturday morning.

APMA gratefully acknowledges the Team APMA 5K Run/Walk sponsors: Title sponsor Valeant Pharmaceuticals North America LLC; shirt sponsor ASICS America Corporation; and general sponsors Amerx Health Care Corporation; Bako Integrated Physician Solutions; Integra LifeSciences Corporation; Spenco Medical Corporation; Vionic Group, LLC and Vasyli Medical; GES; and Projection. ○

Afternoon Schedule Offers a Range of Options

The Friday afternoon schedule at The National offers a variety of presentations so attendees can pick sessions of interest, ranging from an ultrasound workshop to presentations aimed at young physicians to small group discussions covering a range of topics.

Workshop 1: Ultrasound

Presented from 1:30 to 5:30 p.m. in Crystal H, preregistered attendees will learn when different types of imaging technology should be used in diagnosis. Much of the focus will be on the advantages of using ultrasound technology because it provides dynamic images in real time.

Presenters are Nathan H. Schwartz, DPM, Albert V. Armstrong Jr., DPM, MS, and Benjamin D. Levine, MD.

Young Physicians' Program

Four presentations will be used to help young podiatric physicians prepare for practice in a session presented from 1:30 to 5:30 p.m. in Crystal J2-M.

- Paul S. Garrard, MBA, will discuss "Student Debt Management" to help attendees learn how to develop a payment strategy for student loans.
- Scott L. Haag JD, MSPH, and Natasha Pattanshetti, JD, MPH, will present "Compliance" to explain laws such as HIPAA, the Americans with Disabilities Act, and the Physician Payment Sunshine Act.
- Paul A. Kesselman, DPM, and Scott A. Spencer, DPM, will present "Biomechanics and DME" in which they will discuss biomechanics, the use of ankle foot orthotics (AFOs), and regulations related to coverage of AFOs by Medicare or other third-party payers.
- Russell M. LaGreca, CFP, CRPS, will present "Financial Planning Building Blocks for Today's Podiatrists—The New Practitioner." He will focus on two keys to wealth creation—mastering good financial habits and developing a plan—while also addressing common financial questions from young practitioners.

Small Group Panel Discussions

Three sessions of discussions will be presented in two time periods, 1:30 to 3:30 p.m. and 3:30 to 5:30 p.m. The sessions will include presentations and discussions by panels of experts focusing on specific conditions.

Session 1, "The Podiatric Response to Seropositive Connective Tissue Disorders," from 1:30 to 3:30 p.m. in the Diamond Suite, will include Paul T. Dreyer, MD, presenting "Abnormal Blood Pressure Results and Determining When to Make a Referral and When to Just Apprise the Patient of Your Findings." Moderator Elliot T. Udell, DPM, and panelists Molly S. Judge, DPM, and Robert S. Marcus, DPM, will join Dr. Dreyer in the in-depth discussion that follows.

Session 2, "Dermoscopy for both Melanocytic Skin Cancer and Non-Melanocytic Skin Cancer," from 1:30 to 3:30 p.m. in the Emerald Suite, will focus on how podiatric physicians can use a dermatoscope to help evaluate whether skin lesions are benign or malignant. Moderator Ivan Bristow, PhD, FCPodMed, will lead the visual presentation, with panelists Annette M. Joyce, DPM, Bryan C. Markinson, DPM, M. Joel Morse, DPM, and Tracey C. Vlahovic, DPM.

Session 3, "Comprehensive Equinus Treatment of the Podopediatric Patient (Surgical and Non-Surgical)," will be presented from 1:30 to 3:30 p.m. in New York/New Orleans. Moderator Louis J. DeCaro, DPM, and panelists Patrick S. Agnew, DPM, Patrick A. DeHeer, DPM, and Michael E. Graham, DPM, will review the diagnosis and treatment of equinus in pediatric patients ranging from infants to young children.

Session 1, "Achieving Better Outcomes: The Unique Anatomical, Biomechanical, and Hormonal Issues in Female Patients" will be presented from 3:30 to 5:30 p.m. in the Diamond Suite. Moderator Karen A. Langone, DPM, and panelists Elizabeth G. Bass, DPM, Aparna Duggirala, DPM, Alison J. Garten, DPM, Erika M. Schwartz, DPM, and Jennifer J. Spector, DPM, will focus on training for female athletes as well as diagnosis and treatment of their injuries and conditions.

Session 2, "Improving Outcomes with Peripheral Nerve Concepts" will be presented from 3:30 to 5:30 p.m. in the Emerald Suite. Presentations will be: "Peripheral Nerve Entrapment," by James P. Wilton, DPM; "Neurogenic Heel Pain and Use of Diagnostic Ultrasound," by Stephen L. Barrett, DPM; "Impact of Peripheral Nerve Treatment on Balance and Gait," by James C. Anderson, DPM; and "Drop Foot and Nerve Decompression," by Robert G. Parker, DPM. The presenters will then discuss challenging cases in a one-hour panel discussion.

Session 3, "Florida State Laws and Rules" will be presented from 3:30 to 5:30 p.m. in Sago. Robert Frimmell, DPM, is moderator and Jason D. Winn, Esq., general council for the Florida Podiatric Medical Association, will present the course, which all licensed, certified podiatric physicians in Florida are required to attend. He will discuss laws and rules that apply to podiatric physicians in Florida. ○

Forefoot, Rearfoot Treatments Addressed in Surgery Session

Six presentations at the Forefoot and Rearfoot Surgery track Thursday covered a variety of interesting topics, including hallux rigidus, the second MPJ joint, Lisfranc's injuries, flatfoot reconstruction, ankle arthrodesis, and the repair of ankle fractures.

Hallux Rigidus: A Resurfacing Pathology

Several traditional treatments for hallux rigidus involve fusion, but implants are becoming more common and promise the restoration of biomechanics to the joint. The use of implants was discussed during "Hallux Rigidus: A Resurfacing Pathology."

"Most of the implants address the base of the proximal phalanx or both the base of the proximal phalanx and the first metatarsal head. These are known as a single-hinge implant or two-piece implant. When you do that, it changes the biomechanics of the first metatarsal phalangeal joint," said speaker Keith D. Cook, DPM, director of podiatric medical education at University Hospital in Newark, NJ.

With the use of a first metatarsal implant, the diseased side of the joint is resurfaced. Studies of procedures are promising, but reflect only short-term and midterm results, he said.

"Like any implant, you don't know how long it will last, and so there may be a need to do revision surgery," Dr. Cook said. "What is nice about a resurfacing implant is that you are not burning any bridges. If you put in a two-piece implant or a single-hinge implant, to later do a revision surgery generally involves a bone graft."

Second MPJ Joint Pathology: Clinical Diagnosis, Imaging, and Surgical Correction

Second metatarsophalangeal joint (MPJ) pathology is a topic that is frequently debated and controversial. Pathology in this region includes conditions such as crossover toes, plantar plate tears, and monoarticular non-traumatic synovitis. Erin E. Klein, DPM, MS, discussed diagnosis and treatment of these problems.

Dr. Klein, an associate at Weil Foot and Ankle Institute, Des Plaines, IL, and clinical instructor at the William M. Scholl College of Podiatric Medicine at the Rosalind Franklin University of Medicine and Science, briefly reviewed the literature on diagnosis, including radiographic findings and advanced imaging, before discussing methods of surgical correction of lesser MTP joint pathology.

Currently, second MTP joint instability can be addressed through either a dorsal or a plantar approach. The dorsal approaches can use a Weil metatarsal osteotomy, if there is an elongated second metatarsal. New instrumentation that allows the plantar plate to be repaired from the dorsal approach without the osteotomy has been developed, and this might be the instrumentation of choice for revisional cases. The newest instrumentation is the Hat-Trick system.

"Despite the increases in instrumentation for this area and for repair of the instability of this joint, there remains a deficit of true outcome studies following this procedure," Dr. Klein said.

Lisfranc's Dislocation Fracture: To Fuse or Not to Fuse?

Midfoot injuries are a challenge because they can be difficult to diagnose and treat, Roya Mirmiran, DPM, said in her presentation, "Lisfranc's Dislocation Fracture: To Fuse or Not to Fuse?"

"This is a type of fracture that is often missed by emergency room doctors, primary care doctors, and even in podiatry practices that do not see many cases of trauma," she said of Lisfranc injuries. "Even when it is not missed, it can be a difficult fracture to repair, and the outcomes can be less than satisfactory."

The injuries are most often related to sports activities, but also occur at work, often when a heavy object is dropped on the foot. The treatment options are primary fusion or open reduction and internal fixation (ORIF), and each procedure has different outcomes and complications, said Dr. Mirmiran, chief of the foot and ankle surgery section at Health Care System, Albuquerque, NM.

"Those who say you should fuse the joint primarily are the people who believe these patients will end up with osteoarthritis down the road, so why expose the patient to a second, or perhaps a third, surgery?" she said.

If ORIF treatment is used, the patient will need a second operation, which usually is a "planned surgery" to remove hardware, and it is likely that patient would need a fusion later, Dr. Mirmiran said.

"You know that down the road they are at high risk for developing post-traumatic osteoarthritis requiring a fusion, so you should educate the patient," she said of the ORIF option.

Alan J. Block, DPM, MS: "The real key is to treat earlier. Also, remember to treat what you see, not according to the symptoms."

Flatfoot Reconstruction

Flatfoot progresses through four stages that require a variety of approaches, from conservative treatment through surgery. These approaches were detailed in a visual presentation by Alan J. Block, DPM, MS, co-chair of My Leg My Choice and editor-in-chief of the *Journal of the American Society of Podiatric Surgeons*.

"As time goes on, the flatfoot becomes worse and the body breaks down," Dr. Block said. "Unfortunately, the complacency of not having pain and not being aware you are having problems means that you don't address it until you finally start to have pain. Pain usually happens through the soft tissue."

The problems with flatfoot begin in its early stages, often in childhood, when physicians and parents hope the child will outgrow the condition. Unfortunately, a child's bones are not well developed, and so the condition gradually worsens, he said.

"Most doctors base the treatment on pain, and most children can't tell you they have pain because that is all they have ever known," Dr. Block said. "They live with it. By the time they develop a problem, they have had the problem a long time and they just didn't know they had it."

As flatfoot worsens, the patient goes through four stages, and different treatment approaches progress from physical therapy, to the use of orthotics and braces, to surgery, he said.

"If at the point where it is no longer soft tissue and becomes bony, you have to address the bone. You can't just do a posterior tibial tendon reconstruction because the bone isn't going to be there to support you," Dr. Block said. "You are just going to have a collapse again over time.

"At some point you have to start looking at fusions, whether it is at the subtalar joint, the ankle joint, the midfoot, the forefoot, or a combination of these. You have to address the soft tissue and bony deformity."

The focus in treatment, Dr. Block said, is to identify the stage of flatfoot, determine which body part is breaking down, and address it.

"The real key is to treat earlier," he said. "Also, remember to treat what you see, not according to the symptoms. The earlier onset of treatment is the best move because the patient has fewer problems later on."

Ankle Arthrodesis

In "Ankle Arthrodesis," Dr. Mirmiran discussed indications for an ankle fusion and methods of fusion, and compared fusion with ankle arthroplasty.

Fusion is a well-established option for patients with end-stage ankle arthritis who have failed conservative treatments, she said. Long-term data are available to help direct treatment, even when an ankle fusion fails.

Ankle arthroplasty is a newer option that is attracting more interest, but long-term data are not available. Failures are more common with ankle arthroplasty than fusion. There are several options for total ankle implants, but they are not interchangeable following a failure.

In a 2010 study by Saltzman comparing the two treatment options, of 37 patients with an ankle replacement, nine needed a second operation for ankle joint debridement and three needed a polyethyline exchange. In comparison, two out of 23 patients with an ankle fusion had a second surgery due to a non-union.

"With the implant, the technology is still

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developing," Dr. Mirmiran said. "We are still trying different things and learning about them. You have to first get the alignment of the foot right before one can place an ankle implant. If you are going to do an implant, additional adjunctive surgery may be required."

Ankle Fractures: How Do We Fix Them?

More than 580,000 patients with fractured ankles are treated each year in the United States. Because no two fractures are alike, sharing techniques can be useful to all physicians, so Dr. Cook reviewed a variety of experiences during "Ankle Fractures: How Do We Fix Them?"

"Each ankle fracture is different and each patient is unique," he said. "There should be a good surgical plan following standard AO principles. Many techniques are utilized, and there is no cookie-cutter technique for an ankle fracture. You may have to use a variety of techniques."

In his review, Dr. Cook emphasized the importance of anatomic alignment and achieving dynamic congruity. Radiographic evaluation, with a focus on angles and parameters, is key to determine if surgery is required and whether anatomic reduction was achieved, Dr. Cook said. ○

SCANNING SCHEDULE

To receive your CECH, you must scan your badge during each of the noted scanning times*. Below are the scanning schedule, scanning locations, and contact hours available:

Friday

9 to 9:30 a.m.
Scanning in the exhibit hall
2.5 contact hours

12:30 to 1 p.m.
Scanning in the exhibit hall
3 contact hours

3:30 p.m.
Scanning outside the lecture hall
2 contact hours

5:30 p.m.
Scanning outside the lecture hall
2 contact hours

Saturday

9 to 9:30 a.m.
Scanning in the exhibit hall
2.5 contact hours

12:30 to 1:30 p.m.
Scanning in the exhibit hall
3 contact hours

Poster Abstracts Symposium
Scanning in the poster exhibit
1 contact hour

4 p.m.
Scanning outside the lecture hall
2 contact hours

Sunday

10:30 to 11 a.m.
Scanning outside the lecture hall
3.5 contact hours

12:30 p.m.
Scanning outside the lecture hall
1.5 contact hours

*Scanning times noted are for podiatrists and assistants. Pedorthists, refer to the PFA program in the final program book for scanning times.

THE NATIONAL TODAY

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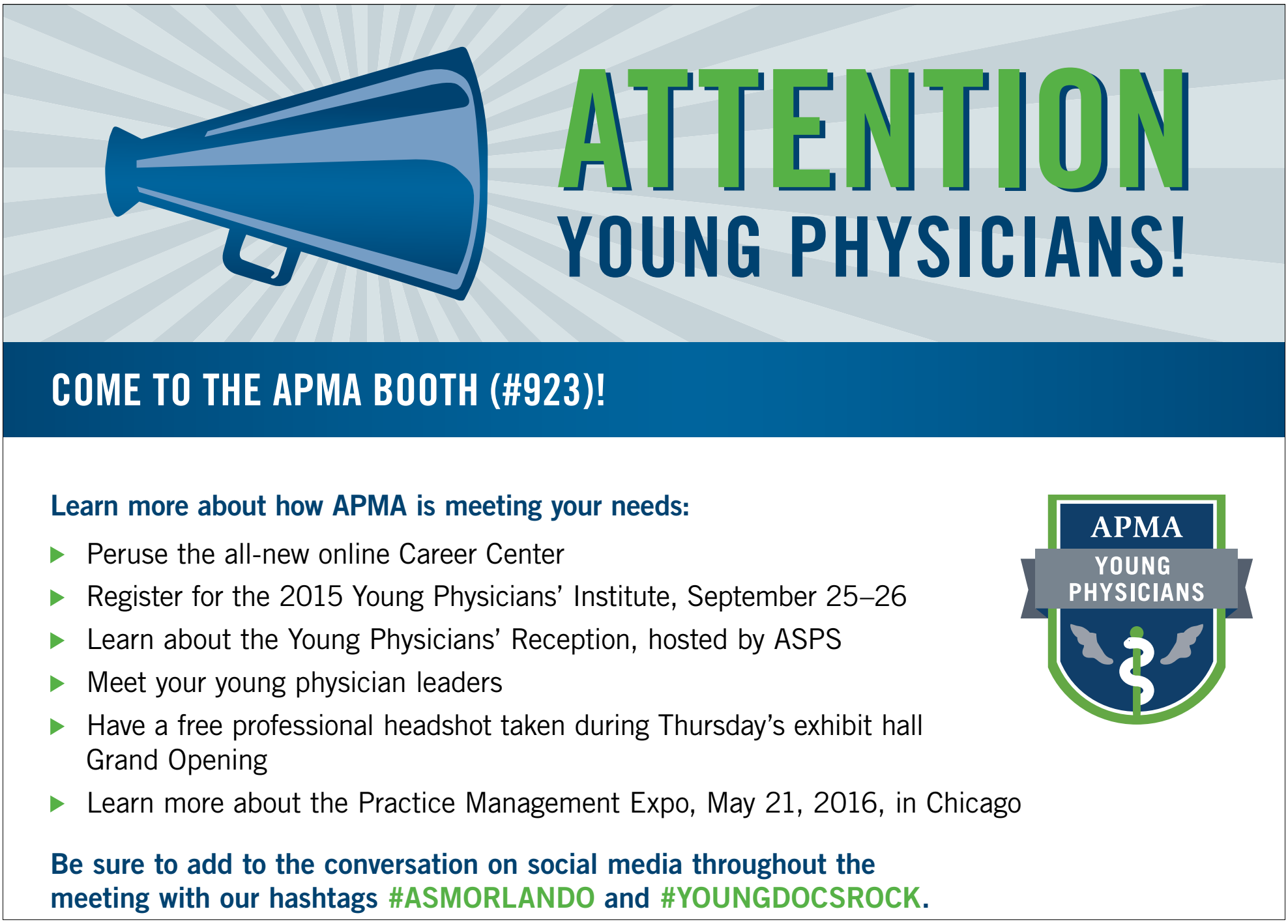


Aggressive Treatment, Casting Vital in Managing Foot Ulcers

The successful management of diabetic foot ulcers should focus on a team approach and aggressive treatment, with an emphasis on the use of non-removable off-loading devices, according to speakers in Thursday's Breakfast Symposium, "The Diabetic Foot and Off-Loading."

"When these patients get wounds, they are easy to get infected because they have a compromised immune system and often have compromised blood flow. The management piece is to aggressively, and in a timely fashion, get patients into a clinic or hospital and treat aggressively early on.

Thursday's Breakfast Symposium drew a full house to hear the latest information about managing diabetic foot ulcers.

Expedient care is what helps them keep their leg," said speaker Vickie R. Driver, DPM, MS, professor of orthopedic surgery at Brown University.

The second speaker, James B. McGuire, DPM, PT, CPed, associate professor in the Department of Podiatric Medicine and Podiatric Biomechanics at Temple University, agreed with an aggressive approach, emphasizing the need for total contact casts.

"The message is to not be dissuaded from doing the right thing because patients beg you to let them out of the cast," he said. "The minute you let someone out of a cast, their healing rate at 12 weeks drops from 85–90 percent to 55–60 percent. If you don't do any off-loading at all, and just rely on a shoe, your healing rates are in the 30s at 12 weeks."

The components for the standard of care management for diabetic foot ulcers are debridement using a scalpel, off-loading, advanced wound care therapies, and interdisciplinary management, Dr. Driver said.

"These patients require interdisciplinary care because they are mostly very sick," she said. "In addition to a podiatrist, they need a vascular specialist, a plastic specialist, an infectious disease specialist, nursing, physical therapy, a cardiologist, and an endocrinologist."

When patients with diabetes present with foot ulcers, they should visit a clinic weekly or every two weeks, depending on the severity of the problem. Because these patients have multiple medical problems, treatment must vary from patient to patient, Dr. Driver said.

"For wound healing, we can use a variety of therapies that are advanced cellular products, such as skin substitutes, growth factors, special sponge dressings that help clear bacteria in the wound, collagen products, or negative pressure that helps pull fluid out of the wound," she said. "These wounds are not all the same. The standard of care is not cut and dried.

"Education should change with each patient, especially new patients. It is important to understand the difference between educational levels. Time should be spent with a patient explaining these pieces to them, not just by the doctor, but by the nurse and the entire team."

Treatment options are expanding with the advent of new technologies and therapies, such as the use of macrophages, fetal foreskin, cellular products, autologous platelets, placenta grafts, and acellular grafts to help heal wounds.

Even with these new options, total contact casting (TCC) should be used instead of less restrictive off-loading devices because data show that the TCC is almost twice as effective in healing wounds, Dr. McGuire said.

"Most physicians don't use the TCC," he said. "In a study of the national database, only 6 percent of diabetic foot ulcer patients have a total contact cast applied during the course of their treatment. Another study showed that only 1.7 percent of centers surveyed utilized a total contact cast for off-loading.

"Eighty percent of podiatric physicians favored walking boots and post-op shoes over total contact casts."

For the treatment of diabetic foot ulcers, a TCC should be used until the wound has closed, Dr. McGuire said. After that, a patient can progress to removable off-loading devices, and eventually their final footwear.

Vickie R. Driver, DPM, MS

"We don't recommend they ever go back to their original shoe," he said. "When the skin first closes, it is not mature enough to handle the stresses of normal walking. Ideally you want to keep patients in some form of off-loading device for an additional three weeks before they are allowed to wear their final footwear. The skin needs to mature to the point where it can handle the tensions and stresses you experience walking in a regular shoe."

Dr. McGuire also recommends that physicians use TCC systems to make it more convenient to use casts in the clinic. He stressed the importance of having a snug-fitting leg section as the key to off-loading with a cast, a fact recently confirmed by the BOOT study (Body mass Obesity Offloading Trial) performed at Temple University. ○

Residency Directors' Workshop Addresses Common Concerns

If you are a residency director or considering starting a residency program, you won't want to miss the "Residency Directors' Workshop" from 9:30–11:30 a.m. today in Crystal J2-M. The session is presented by the Council of Teaching Hospitals (COTH) and the Council on Podiatric Medical Education (CPME).

The workshop will cover several topics that frequently cause confusion for residency directors. First, Charles Lombardi, DPM, and Jeffrey M. Robbins, DPM, will cover "Documentation and Resident Assessment." This presentation will focus on setting behavioral and academic expectations for residents.

As part of the presentation, Drs. Lombardi and Robbins will present several scenarios and then open the floor for discussion of how they should be addressed. The topics will cover everything from a new resident who doesn't live up to expectations to creating a remediation plan when a resident needs to be disciplined. Importantly, the presentation will address how each incident should be documented.

In the second part of the workshop, "Noncompliance: Do I Have All the Documents?" Dr. Lombardi will outline the process of residency approval, the parties involved, and common trouble areas for programs. Included in this presentation will be an explanation of the Residency Review Committee, which is designated by CPME to determine the eligibility for on-site evaluation of residency programs and fellowships. Dr. Lombardi is the chair of the Residency Review Committee.

This part of the workshop will define common terms used in CPME documents and answer questions such as, "What is the difference between a standard and a requirement?" and "What is a guideline?" It will also address a common complaint: "Why doesn't CPME just tell me everything it wants?" Finally, this presentation will identify common stumbling blocks for programs during the evaluation process and explain how these areas should be addressed.

The last presentation during the workshop is, "Logging Podiatric Medical and Surgical Experience." For this presentation, Dr. Lombardi will be joined by Randall L. Dei, DPM, and Oleg Petrov Jr., DPM. Case-logging is one of the most important aspects of any residency program, and it is imperative that residency directors are knowledgeable and comfortable with the process so they can properly monitor the progress of their residents.

The presentation will cover the various categories for which each resident must log cases to meet his or her minimum activity volume (MAV). It is the responsibility of the program director to verify each resident's log with a line-by-line analysis every month, and the director must be aware of the intricacies of each category and subcategory. The lecture will provide attendees with a working knowledge of the PRR clinical log and audit detail report.

Residency directors have the privilege and responsibility to train the next generation of podiatrists. They are entrusted with the future of the profession. This workshop will provide them with the necessary tools they need to carry out their duties and ensure a fulfilling and high-quality experience for their residents. ○

Education in Pain Management, Addiction Is Lacking

Managing patients' pain while determining who is truly seeking pain relief as opposed to just seeking drugs is a growing challenge for physicians, yet it remains an under-emphasized area of medical education. Thursday's Breakfast Symposium, "Pain Management," shed some light on the subject.

"Pain is the most common complaint for which an individual seeks attention, but our education in this area for the health-care profession is inadequate. There is still confusion about the definitions of addiction, physical dependence, and tolerance," said Howard A. Heit, MD, an assistant clinical professor at Georgetown University, who spoke at the symposium.

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. Physical dependence is a state of adaptation that is manifested by a drug-class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid-dose reduction, decreasing blood levels of the drug, and/or administration of an antagonist. Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

About 10 percent of the population has the disease of addiction, excluding nicotine, which affects 19 percent of people.

"Why isn't this taught in medical schools, internships, or residency? Why do our new health-care professionals just coming out of training know very little about addiction and chronic pain treatment?" Dr. Heit asked.

The reward/withdrawal pathway in the brain that controls addiction is the mesolimbic dopamine system. Research shows that those who have a genetic predisposition to addiction have anatomic changes in this area when they use their drug of choice, said Dr. Heit, who is board-certified in internal medicine and gastroenterology/hepatology, and is a diplomate in addiction medicine.

When treating chronic pain, the goals are to decrease pain, increase function, and use medications that do not have unacceptable side effects, he said. To accomplish these objectives, Dr. Heit suggests following his "universal precautions in pain medicine." These include: diagnosis with appropriate differential; psychological assessment, including risk of addictive disorders; informed consent; use of a treatment agreement; a pre- and post-intervention assessment of pain level and function; an appropriate trial of opioid therapy; reassessment of a pain score and the level of function; regular assessment of "the four A's" of pain medicine—analgesia, activity, adverse reactions, and aberrant behavior; and periodic review of pain diagnosis and comorbid conditions.

Howard A. Heit, MD

"Documenting medical necessity also is key," he said. "You have to take time to do this. If you follow the principles of universal precaution, you markedly reduce the chances of getting into trouble.

"These medicines can be diverted and can be abused, but they can be a lifesaver for patients. Your job as a physician is to separate the good, the bad, and the ugly." ○

ABFAS, ABPM Offer Board Certification Guidance

The American Board of Foot and Ankle Surgery (ABFAS) and the American Board of Podiatric Medicine (ABPM) will address common questions during the "ABFAS/ABPM Board Certification Update" at 11:30 a.m. today in Crystal J2-M.

The hour-long session will be moderated by Frank Spinosa, DPM. Steven L. Goldman, DPM, will present on behalf of ABPM, and Christopher D. Lotufo, DPM, will speak on behalf of ABFAS. Each presenter will address an important subject—why certification matters. APFAS and APBM are the only two specialty boards recognized by CPME.

Achieving board-qualified and certified status is likely to become more important in the changing American health-care system. A growing focus on measurable quality care is naturally going to place a greater emphasis on earned credentials.

Dr. Lotufo will cover recent changes to ABFAS, including the name change that occurred last July. He also will address the defined paths to qualification/certification for podiatrists based on their residency programs as well as the difference in qualification/certification in foot surgery and reconstructive rearfoot/ankle (RRA) surgery. Each step of the process has its own window of completion that must be considered.

Regardless of the residency program type, most candidates are eligible to become ABFAS board-qualified following completion of their residency. Once a candidate is qualified, the focus becomes clinical experience. The importance of correctly logging cases cannot be overstated. In fact, 10 percent of failures in the 2014 cycle were the result of incorrectly logging cases.

Dr. Goldman will provide recent updates and news from ABPM, and will also address the difference in requirements for candidates who completed a two-year residency versus those who completed a three-year residency. Specifically, candidates who complete a three-year residency are no longer required to submit case documentation for board certification.

In fact, a podiatrist has the opportunity to become fully board certified through ABPM—that is, sit for both the qualification exam and certifying exam—within a year of completing his or her residency. This expediency allows candidates to take advantage of another benefit of certification: ABPM diplomates report a higher average grossing practice income than the national average for a podiatrist.

Board qualification and certification have numerous potential benefits to podiatrists, including easier hospital privileging and acceptance into certain health-care plans. Don't miss the opportunity to learn more about your options for taking the next step in your career. ○

OPENING SESSION

CONTINUED FROM PAGE 1

"I had to integrate myself into an all-male surgical team," she said. "I was in a country where women didn't have a voice, where a woman didn't dare tell a man how to do a job. But that was my assignment."

After weeks of slowly building a rapport with the Afghan team through a "mutual respect for medicine," Dr. Owens found herself in a bunker after a "horrific explosion." Her phone rang, and it was the head of the Afghan team, who had yet to speak to Dr. Owens. His brief message: "Dr. Owens, we need you. Help."

She ran to the hospital, where she performed life-saving surgery on a severely injured contractor, palpating and clamping his femoral artery and disarticulating his mangled legs. "I learned this on my rotations in residency, not in military training," Dr. Owens said. "The residencies we have established to better train students—I am what they have created."

Dr. Owens doesn't regret her career choice for a moment and said, looking back, she would do nothing differently. But there is one part of her military experience she does lament. In the Navy, podiatrists serve in the medical service corps with pharmacists, microbiologists, physical therapists, and other health-care professionals—not with allopathic and osteopathic physicians.

"It's time for the profession to focus on the federal level, including active duty podiatrists, but also those within the VA," Dr. Owens said. She asked all attendees to visit the APMA booth (#923) or log on to www.apma.org/eadvocacy to support the VA Provider Equity Act.

"If prior to this presentation, you didn't know a podiatrist who was an active duty service member, now you know one. I am a military podiatrist, and I am a part of your family," Dr. Owens concluded. "We must all be ambassadors." ○

President Ward Addresses Attendees

APMA President Phillip E. Ward, DPM, spoke to attendees during Wednesday's opening session, sharing updates on APMA initiatives and exhorting the assembly to support their colleagues through APMA's legislative endeavors.

After taking an on-stage selfie with presidential mascot Rameses, the North Carolina Tar Heels ram, Dr. Ward set joking aside. He advised attendees to take advantage of APMA tools such as publications, the Residency Education Resource Center, the Coding Resource Center, and—in particular—the association's many ICD-10 resources. He also recommended attending Sunday's Ultimate Coding Seminar to prepare for the ICD-10 transition in October.

Phillip E. Ward, DPM

Dr. Ward shared updates on the progress of APMA's two pieces of legislation: the Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians (HELLPP) Act (HR 1221/S 626) and the VA Provider Equity Act (HR 3016).

After touring the brand-new Orlando VA Medical Center yesterday along with other APMA representatives, Dr. Ward told the audience, "It gives you pride to walk through that facility and see what we're doing for our veterans. Podiatrists who care for veterans should have the same rights as other physicians serving our veterans." He encouraged attendees to visit the APMA booth (#923) during The National to help support the VA Provider Equity Act, as well as the HELLPP Act.

Dr. Ward also thanked keynote speaker Kittra Owens, DPM, for sharing her experience and for her service in the US Navy. "Kittra Owens *is* Today's Podiatrist," he said. "She is a physician, surgeon, and specialist. Kittra, I thank you for your service."

Follow Dr. Ward on Twitter, @APMAPresident, or contact him via e-mail at APMAPresident@apma.org. ○

Public Health Challenges

Podiatric Physicians Can Face Unconscious Bias, PTSD, Obesity Issues

Evelyn L. Lewis&Clark, MD, MA: "The focus is on gaining a level of understanding of patients, their cultures, and illnesses so you can begin to relate to them and they can identify with you."

Two speakers in Thursday's Public Health/Disparities session addressed three issues of interest to all health-care professionals—unconscious bias, post-traumatic stress disorder (PTSD), and pediatric obesity—and how they could affect podiatric physicians.

PTSD, Unconscious Bias

Podiatric physicians meeting new patients may focus on their foot problems, but it is important to expand exams to learn more about patients' histories and how those histories might affect overall health. This broader approach was examined by Evelyn L. Lewis&Clark, MD, MA, Thursday in presentations about unconscious bias and PTSD.

"Why is this important as a podiatrist? Because someone who has PTSD, traumatic brain injury, or other behavioral and mental health concerns may present to you with any number of other comorbid conditions, such as osteoarthritis, diabetes, and heart disease, that you would never know about if you don't get a good background and social history," Dr. Lewis&Clark said.

"It may be foot pain, or an ankle injury, or other injuries directly related to the specialty of podiatry. Patients may even present with post-traumatic osteoarthritis, a common and disabling condition in combat-wounded warriors. In fact, osteoarthritis is the most common cause of disability among service members with a medical separation from active duty," she said.

A 25-year veteran of the US Navy, Dr. Lewis&Clark is president-elect of the American Academy of Family Physicians Foundation and chief medical officer for the Steptoe Group. She has a background in family medicine, and social and behavioral sciences, with a special interest in the health-care issues affecting service members, veterans, and their families.

"The focus is on gaining a level of understanding of patients, their cultures, and illnesses so you can begin to relate to them and they can identify with you," Dr. Lewis&Clark said. "This allows for the agreed-upon, negotiated, or prescribed therapy to have optimal impact on their health and health-care outcome.

"We know the essence of mental and behavioral health is stigmatized with many negative connotations. If you do not have a good understanding of that person or have a good relationship with them, whatever you prescribe will fail because they are not going to do it."

Data show that more than 70 percent of US veterans receive care outside the Veterans Affairs (VA) health-care system. It is important for health-care professionals outside the VA system to be aware that while service members and veterans come from a variety of racial, ethnic, and cultural backgrounds, they first identify themselves as military, Dr. Lewis&Clark said. However, each branch of the military has its own subculture.

"In addition, if you name any era or area, such as Vietnam or Iraq, there are significant health issues associated with them. For example, in Vietnam it was Agent Orange, while for Operation Iraqi Freedom, Operation Enduring Freedom, and now Operation New Dawn, it is 'moondust,' a combination of titanium, iron, dust from the sand, and particulate from the burn pit particles culminating in what is now called Iraq-Afghanistan War Lung Disease," she said.

Understanding a patient's culture and background also helps avoid the traps of unconscious bias and health-care disparities, even when treating those who are not veterans.

"If we don't do those things in the forefront, we miss a huge opportunity to provide the quality care everyone deserves, but in particular those whom some of us refer to as heroes," Dr. Lewis&Clark said.

The Impact of Obesity on Physical Activity in the Pediatric Population

Reducing obesity among children has been a focus of health-care professionals and a variety of public figures, such as First Lady Michelle Obama, who has spearheaded the Let's Move! program to improve pediatric health. Those efforts are having a positive effect, but pediatric obesity remains a major problem.

"Even though there has been progress, some groups are still vulnerable and at risk of obesity, and those groups are most underserved populations, such as children from Hispanic, African-American, and Asian-American backgrounds," said Carmen R. Isasi, MD, PhD, associate professor of epidemiology and population health, Albert Einstein College of Medicine of Yeshiva University.

Obese children have health issues that can worsen as they grow into adulthood, when they are at risk for premature mortality, diabetes, and cardiovascular disease, she said.

"It is not just that more children are obese, but the severity of obesity has increased. That severity of obesity is most likely linked to metabolic abnormalities," Dr. Isasi said. "There are several studies that document that the more obese a child is, the more it will affect their blood pressure, the way they regulate glucose, and all the other markers that put them at risk for diabetes or coronary disease."

Research also shows that overweight and obese children eventually have orthopedic complications, from the hips and knees down to their feet. That is where podiatric physicians can play a role by discussing the effects of overweight and obesity on patients and their families.

"Every health-care professional has the opportunity to engage the family. It can be a teachable moment," Dr. Isasi said. "Try to learn not just about the patient at hand, but the issues of the family. Try to educate adults because the adult may have a child or grandchild who could be at risk for obesity. That is a teachable moment."

A topic that should be discussed with patients and families is the relationship between diet and exercise that is important in weight control.

"The cause of obesity is a balance of energy—the things we eat and the calories we expend in our daily activities," Dr. Isasi said. "Physical activity is a protective factor for obesity because it increases the energy expenditure. It has always been shown that the more somebody exercises, the less likely they are to be overweight or become obese.

"Also, studies show that in families that don't eat meals together, children are more likely to have a low-quality diet that leads to excess weight. The family environment is important. Parents are role models." ○

Unique Risk Management Program Comes to The National

Most podiatrists are familiar with PICA's standard risk management program, offered nationwide to help practitioners safeguard their professional reputation—and earn policyholder discounts for liability coverage. But this year, The National offers a new risk management experience that PICA won't repeat elsewhere.

"This was a collaborative effort between APMA and PICA," said Ross Taubman, DPM, PICA president and chief medical officer. "The impetus was to enhance our partnership and provide a unique risk management experience."

First, attend this morning's breakfast symposium, "Vascular Evaluation of the Preoperative Patient and Review of Vascular Complications," from 6:30 to 8 a.m. in Royal. William Marston, MD, a vascular surgeon, will present information on appropriate pre-operative evaluation for vascular complications. Michael Downey, DPM, will review two $1 million malpractice cases with judgments for the plaintiffs, and the physicians will discuss them.

"We're very excited about this symposium," Dr. Taubman said. "It will be a discussion of one of the areas of vascular disease and injury that is a high-risk proposition for podiatric physicians. The session is a unique opportunity to hear an expert in vascular surgery and one of the jewels of podiatric medicine combine their expertise."

Saturday from 8 to 9 a.m. in Sago, attend a plenary lecture, "Will Your Documentation Save You or Sink You?" Thomas Chang, DPM, will focus on common documentation concerns noted in the medical records of podiatrists who have been sued for medical malpractice. Dr. Chang will provide suggestions for honing your documentation skills to create medical records that support the quality care you provide.

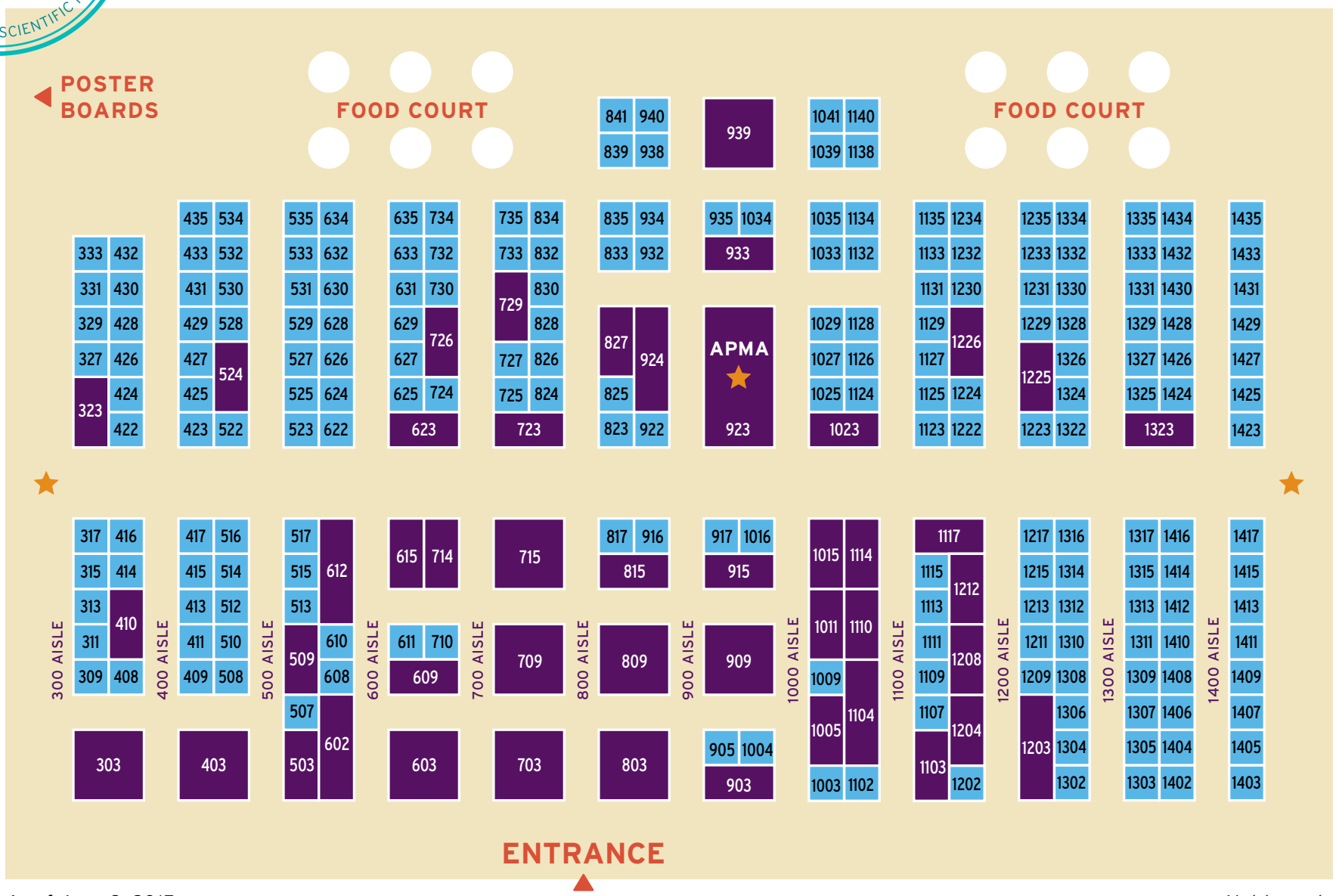
"Documentation is the single greatest challenge to defending podiatric physicians in malpractice cases. In most cases, it's not that their judgment or what they did is problematic. It's that what they wrote down about what they did doesn't match their thought process," Dr. Taubman said.

Dont miss these two sessions. PICA will provide a discount to attendees who participate in the sessions up to the maximum discount allowable in the attendee's state. "The savings on your malpractice insurance more than offsets the cost of attending The National," Dr. Taubman said.

"PICA grew out of an APMA committee 35 years ago," said APMA President Phillip E. Ward, DPM. "APMA and PICA continue to work together to defend the reputations of individual podiatrists and the entire podiatric profession. This year's new risk management program is a product of that shared commitment." ○

THE NATIONAL
JULY 23–26, 2015
ORLANDO
APMA ANNUAL SCIENTIFIC MEETING

EXHIBIT HALL MAP



As of June 8, 2015 *Not to scale*

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TODAY'S EDUCATION HIGHLIGHTS

Plenary Lecture on Melanoma, Presentations of Research Featured

Today's sessions feature speakers discussing treatment and research issues. Subjects addressed will include a look at proper evaluation of vascular issues and the dangers of acral lentiginous melanoma. Also, 15 10-minute presentations of oral abstracts and evidence-based research are scheduled.

6:30–8:30 a.m. in Royal Ballroom, Breakfast Symposium: Vascular Evaluation of the Preoperative Patient and Review of Vascular Complications (Risk Management Program)

William A. Marston, MD, will discuss the appropriate pre-operative evaluation of patients for vascular complications.

Michael S. Downey, DPM, will review two malpractice cases where the plaintiffs won large settlements, and the physicians will discuss them.

8–9 a.m. in Sago Ballroom, Plenary Lecture: Acral Lentiginous Melanoma: What Sets it Apart?

Bradley W. Bakotic, DPM, DO, will discuss the dangers of this skin cancer, which usually develops on the soles or palms and affects patients of Asian or African descent more than any other race or ethnicity.

9:30 a.m.–12:30 p.m. in Crystal G1-AB, Oral Abstract and Evidence-Based Medicine Presentations

The session will start with speakers making eight 10-minute presentations of their abstracts, followed by seven 10-minute presentations of new evidence-based research.

Top Four Residency Interview Tips

Podiatric residency directors on Thursday filmed a roundtable discussion as part of an initiative by the APMA Young Physicians' Program to provide students and unmatched graduates with advice about the residency interview process.

Molly Judge, DPM, of Cleveland, moderated the roundtable, with Vincent Hetherington, DPM, of Kent State University College of Podiatric Medicine; Coleen Napolitano, DPM, of Maywood, IL; and David Yeager, DPM, of Dixon, IL, as panelists.

Here are some of their tips. Watch the full video, coming soon, at www.apma.org/youngphysicians.

1. Some programs require a clerkship to obtain an interview, but most encourage at least a visit. Don't show up cold. "I recommend students research the program," Dr. Hetherington said. "It's easy to go to PubMed. If an institution has written about an area, they're going to ask about it."
2. "If you're going to mention research on a CV, I'm going to ask about it," Dr. Yeager advised. Be sure you were intimately involved in any research you feature on your CV. If you *have* done the research, when interviewers question you, it puts the interview into your hands.
3. It's not just the attendings you must impress. Both Dr. Yeager and Dr. Napolitano reported that current residents can make or break your success in the interview process. If a current resident has a negative experience with a potential resident, it can be enough to take that candidate out of the ranking, Dr. Napolitano said.
4. Some candidates will go through Match Part II, and others may remain unmatched. If that happens, make the most of it. "Stay active in podiatry," Dr. Napolitano advised. Identify what went wrong, and fix your mistakes. Dr. Yeager advised that graduates who don't match should keep in touch with the programs they love.

Dr. Judge concluded the discussion, telling students, "You have more control than you know on the outcome and what your future may bring. ○

REdRC is an online repository of educational materials to supplement residents' daily hands-on experience and is free for APMA members.

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REdRC offers:

Quality—REdRC lectures are generated from experts in the field and are based on competencies identified in CPME approved guidelines for residency education. Created in partnership by APMA, ACFAOM, ASPS, ASPM, and AENS, topics presented through the REdRC cover the full spectrum of podiatric medicine.

Flexibility—Lectures can be accessed anywhere, anytime through the online portal. Residency directors will not have to prepare weekly lectures, and residents will have the opportunity to learn from a range of experts.

Value—When compared with similar products currently available, REdRC represents a tremendous value for residency programs: free for residents who have activated their APMA membership. This is made possible due to the generous support of its founding sponsors, including Gebauer Company, PICA, Organogenesis, Inc., Merz Pharmaceuticals, LLC, Bako Integrated Physician Solutions, Meditouch EHR/HealthFusion, and Acelity.

Growth—Lectures are now up for all three years of residency, and new sessions are added regularly. Additionally, users now have access to the APMA Career Center CV builder, and more tools will be available soon.

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Companies with Products Authorized to Use the APMA Seal

The APMA Seal Program recognizes products that have been found beneficial to foot health and of significant value when used in a consistently applied program of daily foot care and professional treatment. The Seal of Approval evaluates the use of FDA-regulated medical devices and therapeutic agents and their adjuncts (pharmaceuticals). The Seal of Acceptance evaluates footwear, materials, insoles, hosiery, electronic health records/practice management software, and equipment.

Please take a moment to visit our seal-holders in the exhibit hall!

Seal of Acceptance

+MD USA, LLC
Aetrex Worldwide, Inc.
Albahealth LLC
ASICS America Corporation
Bergans of Norway
Black Diamond Group, Inc.
Blundstone Australia PTY LTD
Bobux International Ltd.
Chaco (Wolverine World Wide, Inc.)
Clarks Americas, Inc.
Crescent Sock Company
CrocsRx
Dansko, LLC
Dockers
Dr. Comfort
E.S. Originals, Inc.
ECCO USA, Inc.
Emjoi, Incorporated
FALC S.p.A.
FitFlop Limited
Flagship Brands, LLC
Gildan
HBN Shoe, LLC/Insolia
Heel That Pain
HyTest Safety Footwear
ING Source, Inc.
Injinji Footwear, Inc.
Intersocks D.O.O.
Keds, LLC dba Grasshoppers
Klonelab, LLC (New Balance Licensee)
Longfortune Investments Corp.
McCubbin, LLC (Robeez)
MediTouch EHR/HealthFusion
Merrell (Wolverine World Wide, Inc.)
Momo Baby Inc.
Moon Star, The Foot Company (Marubeni America Corporation)
Pedag USA/Schechen GmbH
Pediped Footwear LLC
Phoenix Footwear Group, Inc.
PolyGel LLC
PROFOOT, Inc.
Propet USA, Inc.
Renfro Corporation
RFA Group
RINGOR
Rogers Corp.
Sanita Footwear LLC
See Kai Run
Shoe Care Innovations, Inc.
SIGVARIS, Inc.
SISA S.p.A.
SKEANIE
Smart Step Therapeutic Flooring
SOLE
Spenco Medical Corporation
Stable Step, Inc.
Strategic Partners
Stride Rite Children's Group
Superfeet Worldwide, LLC
Therafit Shoe
Timberland PRO
Umi Children's Shoes
Unequal Technologies Company
Vionic Group, LLC
The Walking Company
Wellrox, LLC
Wigwam Mills, Inc.
Woodrow Engineering Company

Seal of Approval

Adwill Labs, Inc.
Alde Associates, LLC
Amerx Health Care Corporation
Amniox Medical
Gebauer Company
Innovacyn, Inc.
LaCorium Health USA Inc.
MiMedx Group Inc.
Moberg Pharma NA LLC
Ocean Aid, Inc.
Osiris Therapeutics Inc.
Smith & Nephew Biotherapeutics
Spiracur
Strategic Science & Technology, LLC
The Tetra Corporation
Upsher-Smith Laboratories, Inc.

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