President’s message

I’m pleased to report that the FIP-IFP started 2014 on an exceptionally high note. By the end of January 2014, all financial details related to the 2013 FIP World Congress of Podiatry were finalized. In total, the event included 60 exhibit booths, 940 delegates, 85 lectures and over 1100 people in attendance. A healthy income of over €40,000 was earned.

The 2013 World Congress also generated many additional benefits, such as new videos for our virtual hall. The World Congress also brought new content to the FIP Online Educational programming. Our Online Education program now includes all the lectures and presentations that were captured at the 2013 World Congress as well as new virtual hall videos. Check out numerous photos and pieces from the World Congress. Please make sure to register on our web site at www.fip-ifp.org to see all of our member-only areas of the web page.

Thanks go out to FIP Corporate Partner Spenco for providing an educational grant for this Online Education program. The FIP also obtained a new Gold FIP Corporate Partner, Footmaxx, to join the FIP Corporate Partner Program. This addition came about in part due to their exposure at the 2013 World Congress. Footmaxx is also working with the FIP on another Global Lecture Series (GLS) for 2014. The 2013 World Congress of Podiatry really gave us a jumping off point for all our corporate activities.

Over the weekend of January 31, 2014 the FIP board and staff met in Houston, Texas to formulate the organization’s new strategic plan. The board spent several days to formulate new mission and vision statements as well as identifying several key goals and strategies to move the FIP forward for the next five years. Our preliminary results will be shared with all at the upcoming AGM.

We are looking forward to the FIP Annual General Meeting (AGM) in Iceland on May 10, 2014. Elections for several board positions – member at large, vice president and president – will be held. As well, several new key By-Laws and Articles will be introduced and the AGM will be asked to vote on them. I must stress that it is imperative that all member countries do their best to attend this year’s AGM and, if they are unable to attend personally, they make their vote count by assigning their proxy to a country that is attending. See you all really soon!

Joseph Caporusso, DPM, MPH
FIP-IFP President
Belgium

In 2013, the ABP - BVP has worked on the demand of the Ministry of Health in collaboration with the national Council of paramedical professions to define the legal statute of podiatrists and who will regulate the profession. At this very moment, we are waiting for the signature of the King to have the statute be legally carried out. One of the amendments given our podiatry profession is the ability to assist in Surgery.

On the top of that, we have been active in the creation of a new statute for the “specialized pedicure”. The new title of “specialized pedicure” is a great advancement because the title would finally be the same for both the Dutch- and French- speakers. It is about time that the field of activity of these two professions is made clear to everyone.

Beside all these important advancements, our association and the Belgian podiatrists are very proud that their colleague Carine Haemels, who is the leading lady of Special Olympics on national level, founder and leader for Europe-Eurasia, strong involved on international level and creator of a new education module on podiatry and intellectual disability, became the Secretary general of FIP. We are convinced she will have a lot to offer to the FIP on various aspects.

Canada

Spring 2014 is a very busy season for the Canadian Podiatric Medical Association. One of our key appearances each year is attending the annual Canadian Life and Health Insurance Association conference, which is the largest gathering of insurance companies in one location in Canada. This year’s conference takes place in Quebec City, Quebec. Immediately after that conference, the CPMA will also be attending the 2014 Primary Care Today conference in Toronto, Ontario, which attracts about 4,000 medical doctors from across Canada. Both events provide opportunities to reach out to two of our primary audiences – insurance companies and other medical practitioners.

This year, the CPMA is also holding its Annual General Meeting in the spring, in conjunction with the Region 7 Podiatry Conference that is taking place in beautiful Banff, Alberta. Immediately on the heels of the AGM, the CPMA will be getting ready to fly to Iceland for the FIP 2014 AGM. It is certainly a busy time, but it is worth it for important issues and events.

The CPMA has also been busy re-writing its bylaws to coincide with the federal government’s new Canada Not for Profit Corporations Act. As anyone who has been involved in writing bylaws knows, it is a lot of work. Our deadline for compliance is October this year.

We are looking forward to the meetings in Iceland to re-connect with our colleagues around the world.

Dr. Joseph Stern, President Canadian Podiatric Medical Association

Denmark

The National Association of Podiatrists in Denmark has decided to aim at three major goals which the whole organization will be working on for the next year. Below you can read more about the specific goals and how we intend to reach them.

Increase awareness of how podiatry prevents
1. We intend to increase our communication with the national health services and interest groups. Two of the planned initiatives are videos and a photo book about podiatry.
2. We are currently working on informing politicians about how podiatry is a crucial tool in the prevention of serious problems such as diabetic wounds and amputations.
3. We want to document and create research, e.g. by proving that podiatry prevents amputations.

Improve working conditions for podiatrists
1. To obtain new patients we intend to create PowerPoint slides which can help Danish podiatrists create awareness of podiatry.
2. The public subsidies that Danish citizens on retirement can obtain from the state to have their feet treated are not solely for podiatrists who have obtained an authorization from the state. Therefore, citizens can go to any foot clinic they choose. We would like to make the rules more clear.
3. Longer education for podiatrists is a goal we would like to reach. Therefore, we are in contact with the ministry of education with the purpose of discussing the needs and possibilities of the future education.
4. We are aiming at improving the service of the members by e.g. creating a Facebook profile and start cooperating with the DanAge Association.
5. Few Danish podiatrists are employed in public hospitals and podiatry clinics. We would like to improve the employed podiatrists’ working conditions by systematically examining their conditions among other things.

Increase the public awareness of podiatry
1. Improving communication with the Danes in general is another goal which we intend to reach e.g. by starting to cooperate with a Danish magazine that writes about health.
2. We are planning to participate in events and campaigns such as The People Meeting – Denmark’s political festival on the island Bornholm in June.

**Meetings and conferences**

In March and April, we run a series of meetings in all of the regions of Denmark where all members are invited. The agenda of the meetings is among others the current and future activities, discussion of how we can improve the spirit of solidarity among members in order for them to feel equal no matter if they work for the National Health Service or not.

October 30 to 31 2014, we are launching a large podiatry conference (only in Danish). The program is not ready yet. November 1 2014, the general meeting will take place.

Besides the mentioned activities, we have planned a large number of courses and activities in the local areas.

**Finland**

In Finland we have a new board for our association. We warmly thank our past president Arja Kiviaho-Tiippana for her enthusiastic work for podiatry in our association. The new board has started its work and the new president for next three years is Pia Kallio; others on the board are vice president and international coordinator Minna Stolt, secretary Birgit Salo, treasurer Pirjo Oja and members: Elina Peltola, Mari Hernesniemi and Maija Miikkola. The next big challenge for board is to organize a yearly Finnish Podiatry symposium to members of our association. The Finnish Podiatry symposium will be held 11.-12.4.2014 in Helsinki and it welcomes all professionals interested in foot health to participate.

Following the symposium, the Finnish Podiatry Association will focus on Foot Health Awareness Month in May. The purpose is to raise awareness of foot health and podiatry by participating in different events and organizing small-scale symposiums across whole Finland together with the help of our members.

Happy spring to everyone!

*Minna Stolt, PhD, vice president and international coordinator, Finnish Podiatry Association, SJJL*

**France**

The FNP is organizing an assembly of all stakeholders of the podiatry profession to identify and prospect the future of the profession, looking forward to 2010. This event, which will take place in Paris, will be the highlight of podiatry in France in 2014.

Another initiative of the FNP is a meeting of all stakeholders of the profession (e.g. professional order, unions, societies, institutes, etc) to discuss the future of the National College of Pedicure-Podiatry and present podiatry at the highest institutional level and set the role of podiatrist in the health system.”

**Hong Kong**

Greetings from Hong Kong, we would like to introduce our new IPAHK delegate, Mr. Douglas Horne. Doug is originally from Scotland and has worked in Hong Kong for almost 20 years. Initially working for the government Hospital Authority, he set up his thriving private practice specializing in biomechanics, podopaediatrics and sports medicine. He has several clinics in both Hong Kong and China.

IPAHK has had a very successful year in terms of marketing our association and our profession. We were involved in press conferences and meetings with the government on the registration of Allied health professions legislation. We organized several public seminars on foot health and had publications and media interviews promoting podiatry across the territory.

We hosted several companies at our bimonthly training and development meetings to inform us of the latest products and techniques and were able to introduce a training and development fund for our members. Our corporate partner ‘Strideright’ has had their ‘Steps’ range of shoes seal of approval granted by IPAHK and they have published several articles produced by IPAHK on common foot problems to be distributed in their stores. We welcomed formal clinical training seminars from Prof. Jim Richard and Dr. Tom Chang DPM.

We are looking forward to a busy year ahead as the legal process of professional registration moves forward.

Wishing you all a successful AGM in Iceland and congratulations to Heidi Corcoran, our IPAHK member on being the incoming FIP President.

**Norway**

From the first of January 2014 Fotterapeutforbundet is setting a new standard for continuous education for our members. In short terms, all members have to achieve a certain number of points during a period of three years in order to maintain their membership.

The new act has been widely debated amongst our members for years, and we have hesitated in going through with it due to increased administrative costs for our organisation, and the risk of losing members. But we consider this a necessary step in order to increase the
standards of our profession in Norway. Since regretfully, our government is not taking on the responsibility to assure continuous development amongst their health professionals.

**Biomechanics**
We are experiencing a positive increase of podiatrists specialising in biomechanics in Norway, which resulted in a new special interest group in Fotterapeutforbundet at the end of last year. The new group is a great contribution to our organisation.

**Further Education in Assessment and Treatment of the Foot in Diabetes**
We are very pleased to inform that next fall will be the start for the course “Further Education in Assessment and Treatment of the Foot in Diabetes” which gives 10 ECTS-credits.

We have been working together with Oslo and Akershus University College of applied sciences for quite a few years. We are experiencing a huge interest amongst our members. As many as one out of five wishes to take the course, which implies a huge step in the right direction for lifting our education to college level in Norway, with the University College as an important ally.

*With kind regards, Fotterapeutforbundet*

**Research Work on Diabetic Footwear**
In February, the School of Podiatry JEVIAL with the company Riberox continued with development work on diabetic footwear produced in Peru. This project, Diabetic Footwear, started in April 2013 jointly from the cities of Trujillo, Lima and Alicante (Spain) is now in its final stage, with positive results. The research and development is taking into account the specific characteristics of the Peruvian foot, use of technology and information analysis by professional podiatrists and identification of the market, taking into account social and economic conditions, etc.

We have selected 100 diabetic patients who have delivered prototypes for free and already entered the process of trial and error and, based on technical and functional criteria, podiatrists will make changes and adjustments for a comfortable product that seeks to protect the foot.

Podiatrists Jessica Palomino from Peru and Aranza Requena from Spain have worked together to develop this project. We are confident that in the coming months we can announce the end of the project and also have these products available for the diabetic population and professional podiatrists.

**Signing of Agreement for Project Healthy Foot Development**
The Association “Caring For Your Feet” signed a cooperation agreement with Special Olympics Peru to provide training courses for both professionals and podiatrists to develop health, training and sensitization campaigns for people with intellectual and physical disabilities. It aims to improve access to foot health services for all people with disabilities. The target population is children, youth and adults with physical and intellectual disabilities. Podiatrists will be trained to provide care to improve the quality of life. The agreement was signed in February and the training began in March.

**Peru**

First group of graduates Podiatrists in Piura
*The School of Podiatry JEVIAL together with the Institute “I’M DIABETIC” of the city of Piura, gave the first module of study in podiatry in this city, in which the first group of students graduate with their respective certification.*

A problem for Peruvian podiatry today is the high concentration of podiatrists in the capital city (90%), which is why we are confident in offering more courses of podiatry in different cities of Peru to decentralize podiatry in the country and provide more care to a greater number of people.

**Switzerland**
January 1, 2014, the OPS was born. A single association who regrouped the German-speaking Switzerland and the French-speaking Switzerland, soon joined by the Italian-speaking Switzerland.

The Swiss podiatry Organization (OPS) was created to work all together, in order to be recognized by the basic insurance (LaMal) for diabetic patients.

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Vincent John Hetherington  D.P.M., M.S.

One of the key components of the 2013 World Congress of Podiatry was the strong academic program that resulted in 85 lectures and a poster session both presenting a diverse range of topics. The key figure behind this was Vincent John Hetherington D.P.M., M.S.

As Chair of the FIP’s International Academy of Podiatric Educators, Dr. Hetherington utilized the academy expertise and other resources to put together the congress’s program. As the Senior Associate Dean of the Kent State University College of Podiatric Medicine, he already had a good relationship with many educators around the world, which enabled him to reach out to many qualified speakers.

Dr. Hetherington’s credentials include a Doctor of Podiatric Medicine and a Master of Science Program in Podiatry Surgery, both from the Pennsylvania College of Podiatric Medicine (now Temple University School of Podiatric Medicine). He also has Board Certification by the American Board of Podiatric Surgery in Foot and Ankle Surgery. He is also a Fellow of the American College of Foot and Ankle Orthopedics and Medicine and the American Society of Podiatric Surgeons.

In 1986, Dr. Hetherington was awarded the Fogarty Senior International Fellowship, Department of Health and Human Services, Public Health Services, NIH for the study of chronic foot problem at the Institution Orthopadisches Spital in Vienna, Austria. In 1989, he was part of a U.S.-Austria Biomedical Exchange Program, sponsored by Fogarty International Center and The Austrian Science Foundation at Institution Orthopadisches Spital in Vienna, Austria.

Dr. Hetherington is the author of multiple textbook chapter, clinical and research journal articles. He is also a member of the editorial board of The Foot.

Dr. Hetherington has also edited three medical texts:

- **Principles and Practice of Podiatric Medicine, Second Edition**: Ed. Leonard A. Levy, DPM, MPH and Vincent J. Hetherington, DPM, MS, 2006 Data Trace Publishers, Brooklandville, Md


With Dr. Hetherington’s commitment to podiatry, and acknowledged expertise and experience in podiatric education, it is obvious why the FIP awarded him the Distinguished Service Award in October 2013.

Congratulations Dr. Hetherington!
Big events such as this do not happen by themselves. They require a significant amount of planning and coordination. The 2013 congress included considerable involvement from the FIP Board, the Italian Podiatry Association, the International Academy of Educators and a hired conference management company. The coordination of all these components was significant, but was smoothly dealt with by two key individuals – Robert Chelin, DPM and Jayne Jeneroux. As the FIP CEO and Executive Director, these two individuals oversaw every detail of the world congress, from creating promotional materials arranging spousal activities and excursions to negotiating hotel rates and troubleshooting any issues that arose.

One such example was the last minute change of one of the planned plenary lectures. Due to a travel glitch the speaker was unable to attend in person, so arrangements were made overnight for a virtual presence instead. Dr. Caporusso and Dr. Hetherington quickly stepped in to provide the “hands-on” component of the lecture. Both Jayne and Robert worked around the clock, literally, to ensure that every aspect related to the world congress was taken care of. Both quickly adapted to a work week of 24/7, constant calls with the conference organizers in Italy, which meant early morning calls to accommodate for time zones, weekend calls, and late night calls with the FIP President and Academy Chair. In the end, they each logged in over 1000 hours.

In addition to the work involved to ensure a smooth-running world congress, Robert and Jayne also provide ongoing behind the scenes for other key aspects of the FIP. Robert is the webmaster for the FIP’s massive internet site. He manages the day-to-day activities generated through the website as well as seeking new content for the site. He also approves and registers member access and manages the PayPal account. As FIP CEO, Robert also serves as an advisor to the FIP president and board members. His historic background of the FIP makes him invaluable to the day-to-day workings of the FIP.

As Executive Director, Jayne is also involved in just about every aspect of the FIP and provides the continuity for the FIP board and its new board members. As the first point of contact for most people, Jayne deals with a broad range of queries, issues and concerns. She also works with the FIP board, both as a group and with individual board members. Jayne also works with FIP committees, such as the World Foot Health Awareness Month and Special Olympics. She is also the editor of the FIP’s quarterly magazine, Footsteps. From researching topics and clinical studies, writing articles and securing advertising, she also works closely with a graphic designer to ensure each issue’s vision, edits proofs and more. She also writes eblasts, coordinates and organizes all the board’s phone/skype/in-person meetings, prepares draft agendas and minutes and coordinates notices, eblasts, etc. Her savvy negotiation skills are also well used in securing great prices for all FIP-related meeting space, promotional materials, etc.

Robert and Jayne also work in tandem on many priorities, such as PowerPoint presentations, speeches, operating documents and more. With the reputation of the FIP foremost in their minds, they work quietly behind the scene to ensure that the FIP and its board grow as an organization and provide information, lectures and other resources for its members. Much like the IT department of a big company, the fact that people don’t notice their work means that things are running smoothly.
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Nine Steps to Preventing Internal Fraud

Internal fraud is perpetrated from within the business by its employees. Unfortunately, this constitutes the most common type of fraud. Use the following tips to help develop a fraud prevention program for your business.

1. Know your fraud risks: Determine where your company’s specific vulnerabilities lie in order to create and implement internal prevention controls.

2. Employee background checks: Check references, employment and educational history to ensure there’s no previous history of fraud or illegal activity. If you’re filling a position managing the company’s assets, you may want to consider conducting a credit check with the authorization of the candidate.

3. Ensure monitoring of cash situations and create system of checks and balances: Have security cameras installed to monitor activity at registers and in inventory storage areas. Fraud is less likely if people know they’re being watched. Expenditures should always have a multi-step approval process consisting of a manager and an accountant to ensure validity of expense and to run the math. Additionally, key business functions should never be handled by a single employee, this makes fraud easier to conduct and to cover up.

4. Conduct surprise audits: If you do not have internal auditors, have your accountants periodically visit and audit specific functions of your business where fraud might occur. These audits are less designed to discover fraud and more to act as a deterrent as employees will know it will be more likely to be uncovered.

5. Control the banking: Small business owners should check bank statements themselves to avoid cheque tampering. Watch for missing cheques, cheques issued out of sequence, unknown payees, cheques which look altered, cheques not signed by authorized signatories, or any other unusual items. Conduct bank reconciliations once a month and consider using online banking tools if you regularly have many transactions and large dollar volumes.

6. Use only approved vendors: This can help fight billing schemes and phony invoices. A list of management-approved vendors should be available to all staff and this list should be routinely checked against invoices. Look for unknown vendors, vendor names similar to approved vendor names, vendors with no physical address or phone number or vendors with addresses matching an employee’s address.

Small businesses often have limited resources for fraud prevention programs. Yet, they are among the biggest targets for fraudulent activities with revenue losses related to employee-perpetrated fraud estimated at $3.2 billion per year according to Canadian accounting associations. To avoid falling victim to fraudulent activities, small businesses should take steps to identify and prevent risks for fraud in their organizations.
7. Create and communicate your company’s fraud policy: Make all employees aware of what activities constitute fraud, the tools being used to combat it and the company’s zero tolerance policy on fraud. Ensure employees know what to do and who to contact if they suspect fraud and be sure to inform employees about the actions the company will take if it is determined fraud has been committed. Often the communications themselves become a deterrent to fraudulent activities.

8. Employee Assistance Programs: Often internal fraud is committed by employees undergoing dire hardships and feel they have no other alternatives. An employee assistance program can help mitigate this risk and if a formal program is too expensive, institute an open door policy where employees feel they can approach management for help when it is needed.

9. Take action when fraud is discovered: Obviously the punishment should match the offense but having a fraud policy is useless if you are unwilling to enforce it. Once small frauds are overlooked or permitted without repercussions, larger ones become possible. Consider options such as suspensions, demotions, salary cuts, probation, dismissal and legal action for differing levels of violations.

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**Preventing Common Types of External Fraud**

There are a number of scams targeting small businesses that range from strange office supply orders to bills for advertising that was never ordered. Often careful attention and verification can prevent businesses from falling victim to this type of fraud.

1. **Domain name renewal**: Small businesses with their own websites can be confused or caught by unsolicited letters warning them that their Internet domain name is expiring and must be renewed. Sometimes these letters offer them a new domain name similar to their current one. If you have a registered domain name, be sure to carefully check any renewal notices or invoices you receive.

   - Check that the renewal notice matches your existing domain name. Watch for small difference like “.org” instead of “.ca” or missing letters in the web address.
   - Check that the notice comes from the same company with whom you registered the domain name.
   - Check your records for the expiry date of your existing domain name and see if this matches the notice.

2. **Business directory listing or other unauthorized advertising**: This type of fraud may be disguised as a solicitation for an update of an existing advertising product you have purchased or as an offer for a free listing when it is actually an order for a listing requiring payment at a later date. Other times, the communication may be in the guise of an order form originating from well-known advertising suppliers when it actually isn’t. Often, if the offer seems too good to be true, it usually is.

3. **Office supplies**: Small businesses may receive invoices for goods they never ordered. Often this will revolve around items you may order regularly such as paper, printing or maintenance supplies. Be sure to keep records of all orders placed and check these against all invoices received. In other instances of this type of fraudulent activity, businesses may receive phone calls which falsely claim to be from their “regular supplier” with a limited time or special offer. These calls often wish to confirm your address or an existing order. Supplies offered in these calls will be overpriced and of bad quality. Always deal directly with your supplier contact or insist that you will call the caller back, at which point you can dial your regular supplier to confirm this offer is indeed from them.

4. **Equip your front lines**: Make sure your staff processing invoices or answering phone calls is aware of these types of fraud as they will often be the main points of contact. Always check that goods or services were ordered and delivered before paying an invoice.

5. **Be careful about your business information**: Never give out information about your business for advertising purposes unless you know how the information will be used and you can confirm you are dealing with your standard advertising supplier.

6. **Get it in writing**: Never accept a business proposal over the phone. Always request the offer in writing and limit the number of people in your company who have the authority to approve purchases or create a multi-level approval process.
Getting ready for World Foot Health Awareness Month in May

The FIP encourages all FIP member associations and their members to celebrate May as World Foot Health Awareness Month. A full month dedicated to creating awareness about the importance of foot health provides so many opportunities.

The FIP has been helping member associations with this promotion through the development of yearly campaigns focused on a particular theme. As announced in the 2013 December issue of Footsteps, the 2014 theme is Nail and Skin Health.

If you haven’t yet planned your May 2014 awareness campaign, you still have time by using the materials already prepared by the FIP for its members. This year’s materials include a country specific poster, a theme-specific special introduction document, a true/false quiz, do’s and don’ts, frequently asked questions and a resource guide and corporate partner guide.

You can download these materials from the FIP website – www.fip-ipf.org. On the front page, click on the WFHAM globe.

Take advantage of your FIP member benefits by using the materials prepared for you. Make May 2014 your best campaign yet to increase awareness about foot health and podiatrists among the general public and other health professionals.
New research suggests that idiopathic toe walking, long considered a gait pattern that occurs in the absence of other abnormalities, may have an underlying neurological cause. Investigators need to undertake more research to confirm this early hypothesis, but, until more is known, researchers suggest that clinicians be alert for subtle signs of other sensory and motor skills issues in children with the diagnosis.

It’s normal for toddlers to walk on their toes as their gait develops, but when this pattern persists in children older than two years, it’s a cause for concern. Toe walking can be the first sign of neurological or developmental condition such as cerebral palsy or autism spectrum disorders. In addition, bilateral toe walking is often seen in children with congenital muscular dystrophy and global developmental delay. (Unilateral toe walking is typically the result of trauma.)

“Ultimately, the diagnosis is given when there is no medical reason for toe walking,” said Cylie Williams, PhD, a podiatrist with Southern Health, Cardinia Casey Community Health Service, Cranbourne, Australia.

Williams and her colleagues have developed the Toe Walking Tool, a validated 25-item questionnaire that can help practitioners identify otherwise healthy children who toe walk as well as reveal risk factors for other medical conditions that may require further evaluation from a specialist.

Although Williams’ tool is used to rule out these well-characterized conditions, her recent work has lead her to suspect the gait pattern may not be truly idiopathic, but instead, “the result of some very mild neurological changes we still don’t understand.”

Williams noted that several studies have described increased sensitivity to vibration and hypersensitivity in the hands or feet in children and adults with Asperger syndrome and autism spectrum disorders and that gait changes, including toe walking in children, are linked to these disorders.

In 2010 Williams and her colleagues completed a literature review on the relationship between toe walking and sensory processing dysfunction. They found only a handful of studies that discussed a potential link between ITW and sensory processing issues, but noted that clinical observations and anecdotal reports of the possibility of such a connection were becoming more common.

To test whether children diagnosed as idiopathic toe walkers might also demonstrate changes in sensory processing, Williams and her colleagues recruited 30 healthy children aged 4 to 8 years who were not toe walkers (NTW) and 30 children in the same age range who the researchers identified as current idiopathic toe walkers using the exclusionary toe-walking tool.

They measured the children’s vibration perception threshold (VPT) in the right hallux using a vibratory sensory analyzer that delivers a frequency vibration of 100 Hz (amplitude range, 0-130 µm) through a Teflon-coated pin mounted in a footplate (Figure 1). The vibration mimics the everyday tactile input that allows the brain to sense fine surface texture changes, which, in the feet, play a key role in protection and proprioception.

The results, e-published in March by the Journal of Child Neurology, showed that the children in the toe-walking group had a significantly lower VPT than those in the NTW group (mean, 1 µm vs 1.8 µm; P = .001).

“The vibration study paper highlighted a difference in tactile sensory perception, or heightened feelings of touch, that the children with ITW had, indicating that these children were perhaps more sensitive in some way to touch,” Williams said. “We tested this as part of a larger study of the motor skills and sensory processing abilities of children who have an ITW gait. The rest of the results are being finalized for publication, but we found that children who had an ITW gait had problems with some specific gross motor skills and displayed some unusual behavioral changes as a result of different sensory input. This result indicated there might be some immaturity or difference in the way the children who have an ITW gait process sensory input.”

During data collection for the larger study the Australian researchers turned up an unexpected finding that also hinted at some neurological basis for ITW. They recorded the preferred hand of each child in the ITW and NTW groups and found that only 10% of the children in the NTW cohort preferred their left hand, a result that is in line with population norms. In contrast, 33% of the children in the toe-walking group preferred their left hand.

Previous research has linked left handedness to difficulty with spatial tasks and dyslexia.

“The left-handedness result also feeds into this [the theory that children with ITW may have a mild neurological condition], and, while the children may be genetically left handed, there is also the possibility that the left handedness is neurologically based,” Williams said. “This result again points to the ITW gait being the result of some mild neurological impairment. The study on this cohort of children who appeared to be neurologically normal but toe walked...
found that there were all these interesting little signs that, in fact, the toe walking may actually be the result of some very mild neurological changes—but we’re still not sure what these might involve.”

Pär Engström, MD, is a consulting orthopedic surgeon at Astrid Lindgren Children’s Hospital in Stockholm and a PhD candidate in the Division of Pediatric Neurology, Karolinska Institutet, also in Stockholm, who will defend a thesis on ITW in December. Engström has authored several studies on the condition, including one currently in press that examines neuropsychiatric problems and symptoms in children with ITW.

Engström told LER, “I also believe ITW is mainly neurogenic. But at present we do not know. As much else about ITW, this is just a theory. As Williams et al conclude in their review about sensory processing, there are no studies yet that can say that sensory processing is a cause of ITW, but that does not mean it is not so. ITW children do have more neuropsychiatric problems than children without the condition and that is probably an indication of a neurogenic origin. More studies are needed!”

The takeaway from this work, Williams said, is a need for healthcare providers to consider the whole child rather than their gait pattern alone.

“There may be social and behavioral concerns that impact the child, especially in the area of sensory and gross motor skills. Healthcare providers also need to give parents realistic expectations of treatments, as there is no current evidence to support any one treatment as being 100% effective and this neurological reason may be why,” she said. “Often the treatment used for kids with ITW focuses on tight gastroc and soleus muscles, and, while this is a continuing priority, consideration should be given to other problems and a referral to occupational therapist, neurologist, pediatrician, or child psychologist may be in order.”

Treatment

Treatments for ITW include stretching exercises, serial casting, ankle foot orthoses (AFOs), night splints, surgical lengthening of the triceps surae muscle complex, and, most recently, botulinum toxin A injections, which result in a temporary flaccid muscle paralysis.

Two small case series have tested the effect of botulinum toxin A (Botox) in ITW. In 2004 Jacks et al treated 10 children aged 2 to 17 years with a single injection of botulinum toxin injection followed by night splinting; toe walking resolved in seven of the 10 children.

Brunt et al reported on a series of five children with ITW who underwent bilateral botulinum toxin injection in the gastrocnemius and soleus muscles. Their goal was to retrain the muscles and normalize ankle function as measured by electromyography. Twenty days after injection the children received physical therapy to the gastroc-soleus muscles.

Before injection initial contact was limited to the toe or was digitigrade in 51% of the children; at 20 days post-treatment only 8% of the children’s foot contacts were toe or digitigrade. Before treatment gastrocnemius onset occurred a mean of 30 ms before foot contact and the duration of swing phase tibialis anterior activation was attenuated (345 ms). After treatment gastrocnemius onset occurred a mean of 36 ms after foot contact and duration of tibialis anterior activation increased through terminal swing and into the loading response phase. The post-treatment improvements were maintained at 12-month follow up.

Engström and colleagues examined the effects on gait of botulinum toxin injection followed by stretching exercises for the calf muscles five days a week plus at least 50 heel-to-toe steps per day. The 15 children (aged 5-13 years, five girls) were toe walkers and were examined by a pediatric neurologist to confirm the absence of underlying neurological or muscular pathology. Patients received four injections of botulinum toxin A in each calf, two in the proximal third of the lateral and medial gastrocnemius bellies and two distally in the gastroc-soleus complex.

The children underwent 3D gait analysis and passive range of motion measurement prior to treatment and at three weeks and three, six, and 12 months after injection. Parents also rated their perceptions of the amount of toe walking before treatment and at six- and 12-month follow up (only 11 children were available at 12-month follow up).

At 12-month follow up parents reported that three children had completely stopped toe walking and four had decreased their amount of toe walking by 25% to 50%. In four children the amount of toe walking was unchanged. After six to 12 months, nine of the 14 children for whom data could be assessed experienced improvements in toe-walking severity classification.

Gait analysis for the entire group showed all children had a significant improvement in the amount of ankle dorsiflexion achieved in stance; however, Engström noted, almost all the children’s ankles after treatment were still in a plantar flexed position.

“The obvious goal of ceasing toe walking was only occasionally reached,” Engström said. “This is a nonrandomized study with only 15 participants, so it is hard to draw many conclusions, but I am doubtful that Botox has a place in management of ITW. We are conducting a randomized controlled trial comparing plaster casting alone with a combination of plaster and Botox that will show more reliable results.”

A 2012 review article by Oetgen at al reported that the results of nonsurgical management of ITW are mixed, but that conservative interventions (including stretching exercises, serial casting, and botulinum toxin injections) have been most successful in patients with a baseline ankle dorsiflexion greater than or equal to 0°.

Oetgen et al concluded that surgery, which lengthens the triceps surae muscle-tendon complex, should be reserved for patients with fixed equinus contractures or those who do not respond to conservative treatment.
Orthotic options

Orthotists have reported good results with AFOs, and, more recently, with even more minimal devices.

Research presented at the American Academy of Orthotists and Prosthetists annual meeting in March, for example, suggested that treating children who are toe walkers with a rigid footplate may yield better long-term outcomes than using an AFO—the traditional and more restrictive orthotic treatment for ITW (See “Off their toes: Lower profile device aids toe walkers”).

The results of that research showed that children who wore a full-length carbon-fiber footplate tended to have a better carryover effect once out of the device than children who wore an articulated AFO that completely blocked plantar flexion at the ankle joint.

Mark Geil, PhD, an associate professor of biomechanics at Georgia State University in Atlanta who presented the results, noted, “The footplate still allows children to toe walk if they try. The better carryover we saw with the less restrictive device led me to what I call ‘the rebellious teenager theory.’

That is, the more restrictive device resulted in more regression because children don’t accept total restriction as easily as more gentle orthotic encouragement.

Orthotist Kevin Matthews, CO, LO, owner of Advanced Orthopedic Designs in San Antonio, TX, also prefers the minimalist approach to orthosis design for ITW. He reports excellent success using a custom supramalleolar AFO modified with a plantar flexion stop (Figure 2).

“Walking on their toes feels natural to these children, but when we cue them to walk on their heels, most can do that. So, if they can heel walk and they have normal tone, they’re a candidate for this design,” he said. “The traditional designs for this condition are hinged AFOs with a plantar flexion stop that goes almost all the way up to the knee. It’s a lot brace of to wear, and it forces the child to walk in a heel-toe gait pattern.”

Matthews, who has fabricated more than 100 pairs of the low-profile SMO for children with ITW, maintains that encouraging rather than forcing the child into a normal gait pattern means patients use their own muscles to walk rather than relying on the brace.

“The SMO helps them establish a new gait pattern on their own and this device is much less visible than a hinged AFO—only about two inches stick out of the back of the shoe and the sides—so it’s not obvious at first glance that the child is wearing a brace,” he said.

Matthews said he had heard about the use of the rigid carbon footplate to treat toe walking, but has been hesitant to try it.

“I have offered it to a few patients, but as yet no takers. It would help to have more information published on the approach. These are not covered by insurance and we charge $60 each,” he said. “The approach makes sense and I feel it may well be a viable option and have told my patients that. My concern is that it doesn’t impact all phases of gait—the [Georgia State researchers] results are nowhere near as good as I have been getting.”

He is confident enough in the modified SMO design to offer parents a no-risk deal: if parents aren’t happy with device at any point during the six month treatment, he’ll fabricate the more expensive hinged AFO at no cost. He says he’s only had to do this once.

“I replaced it [the SMO] with an AFO on the physical therapist’s recommendation,” he says. “The patient was compensating by flexing at the knee to walk on his toes. I was sure he would not continue to do so, but they requested the AFO and I didn’t argue the point.”

Matthews noted, however, that children must wear the SMO during all waking hours to be effective and, if the parents aren’t willing to enforce this wear, the brace is not a good option for their child.

“My goal is to use the minimal intervention that is effective. For children who toe walk, this little brace works superbly,” he said.

References

You may spend thousands of dollars to boost marketing. You could have the best new technological widgets and gadgets podiatry has to offer. You might even have a bedside reputation like that of Grey’s Anatomy’s Dr. McDreamy and yet, first time patients would never even know. What if something simple stood in the way of a new patient ever meeting you? Losing these patients could easily be the result of a poorly functioning front desk. What you don’t know, can hurt you. Getting your front desk functioning at 100% involves having certain systems in place.

Here’s Part I of a two part article to get you started.

Phones: How are your phones being answered? Quick and cold [“Hold please!”] or attentive and caring? “Good morning, Dr. ___’s office, Dawn speaking. How can I help you?” Does the caller get an initial feel good moment? [It only takes 4 seconds to form that first impression.] Do they get that they are speaking to a qualified professional? Are they satisfied; getting questions answered promptly and accurately? Does the dialog convince the caller that seeing the doctor and making an appointment is the best medicine or are they compelled to hang up and call elsewhere? Does your staff have prepared scripts to help guide conversation, assure appropriate response, or are they giving off the cuff, anecdotal and more importantly, unauthorized medical advice? You should know.

Scheduling: Regardless of what EMR system used, digital schedules can be programmed to align a correct amount of time to each individual procedure or code. Yet, more often than not, offices insist on utilizing the “old standby” 10/20 minute blocks...for everything. Proper scheduling includes understanding the difference between a complicated vs. a routine vs. a follow up visit; knowing what questions to ask to appropriately triage calls; when it’s feasible to double book patients [and when not to]; and understanding [with the doctor’s input] how much time each procedure takes in order to effectively manage the schedule. Inexperienced, random scheduling leads to patient flow issues, frustrated staff, rushed physicians and disgruntled patients. If discussion about better scheduling strategies is not on the staff meeting agenda to discuss making necessary amendments, it should be.
**Wrong staff positioning:** It is essential to make sure that all front desk personnel demonstrate an acceptable level of control, but are not controlling; polite, not demanding; friendly, but not needing to be friends with every patient, and knowledgeable, but not a know-it-all. Sounds simple enough and yet, if I only had a nickel for every misplaced staff person [whose shortcomings could not justify them sitting in that “hot” seat] and another nickel for the excuses that keep them there... well, I would be writing my articles from the coast of some exotic location. When I interview a receptionist who admits they’ve been trained and would rather be working in a clinical setting – bells and whistles go off. Put people where their strengths are and they will be more productive.

**Inconsistent, unwritten or unenforced policies:** Written policies are a critical part of every practice; without them, there is chaos and confusion. Policies [or rules] set protocol. They assure that all activities are conducted in a similar manner and put everyone on the same page. Some of the essential front desk include requirements for staff handling money; patient financial responsibilities, copay collections, dealing with missed, cancelled and late appointments as well as walk-ins, no shows and emergency; physician-referred patients; and missing insurance referrals – just to name a few. Remember, a written policy without discussion, training and enforcement is only a static piece of paper. To make policies meaningful, there must also be consequence for non-compliance and they should be carried out not just “some of the time” – consistently, across the board. Someone needs to be in control of that front desk. If you [or your staff] aren’t, the patient is.

**Tools for success:** Operational systems that we sometimes take for granted at the front desk must be immediate and rooted, or quickly at their fingertips, not down at the end of the hallway, or “Can I get back to you with that?” Those systems include procedure “how to” and policy manuals, clear cut job delineations, website appointment scheduling, access to online insurance websites, automated appointment reminders, scanner, shredder, online or onsite fax, updated computer software, digital card readers, credit card machines, hands-free headsets and ergonomically-correct seating. Having easy access to equipment and keeping it in working order sets staff [and the practice] up for success, not failure.

For each difficulty presented, there is a solution...and before you can fix them, you must identify them. Check back because in our next article, we will address additional factors of contributing front desk inefficiencies, e.g. inadequate training, front office/back office communication gaps, collections, lack of attention to detail [data input errors] and indifferent customer service.

Subject to be continued next issue...

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Ms. Homisak, President of SOS Healthcare Management Solutions, has a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management’s Lifetime Achievement Award and recently inducted into the PM Hall of Fame. Lynn is also an Editorial Advisor for Podiatry Management Magazine and recognized nationwide as a speaker, writer and expert in staff and human resource management.
FIP country membership has grown substantially over the years, and now boasts 32 countries. With members located throughout the world, it is impossible for everyone to meet in one location for a scientific conference. The FIP addressed this dilemma, in part, by creating an online education component on the FIP website. Over the years, a variety of educational courses have been added. In keeping with the FIP’s mission statement, education for members has always been a priority. Now, more than ever, members have the opportunity to access a variety of educational materials through the FIP.

Online education on the FIP website
Knowing that education is an important factor for FIP members, in 2007 the FIP reached out to educational partners around the world to provide content for an online education component on the FIP website. Currently there are 8 lectures with another 8 coming shortly and will be available for free to all FIP members. We anticipate adding several more in the coming months. NOTE: You must register and log in as a member on the FIP website to access these courses.

World Congress Educational Capture
The 2013 FIP World Congress (WC) of Podiatry provided an ideal opportunity to increase educational content for FIP members through our website portal. Over 85 PowerPoint presentations, including their audio, were recorded. All of these presentations are now up on the FIP website. If you were in attendance but would like to have a chance to view all presentations at the 2013 WC, you can review all the presentations at no charge. If you were not able to attend the 2013 WC, you can still take advantage of this opportunity. The educational capture of the lectures are now posted on the FIP website, and is available for a nominal fee. Following the presentations we encourage you to visit our exhibitors in the Virtual Hall.

FIP Virtual Hall
The FIP Virtual Hall was launched in 2007 at the FIP World Congress in Copenhagen. In addition to providing an overview about the world congress, it also provided viewers the opportunity to check out many of the exhibitors demonstrating their products and their services. At each and every world congress, the Virtual Hall gets updated with content. Check out the 2013 editions on the FIP website, it is like going to a conference in the convenience of your home or office.

Global Lecture Series
The newest educational activity of the FIP is the development of a Global Lecture Series. The series evolved from FIP Corporate Partner Spenco wanting to reach out to podiatrists in South America. Working with Aldo Palomino, the FIP’s liaison in South America, the FIP and Spenco developed a lecture program. The success of this program sparked the idea for the global lecture series. In 2013, Footmaxx signed up for three lecture programs in three different countries (Peru, Mexico and Chile). The success of the 2013 event has already resulted in Footmaxx signing up again for a series in Europe in 2014. While the lecture series doesn’t allow all FIP members to access education, it does provide education for many countries that are unable to travel to events such as the FIP World Congress.

A special “thank you” goes out to Spenco for its educational grant support of the FIP Online Education Program.

FIP = education for members

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Mark Your Calendar

**DATES**

**2014**

**International Region 7/APMA Podiatry Conference**
Banff, Alberta
http://www.region7apma.org/annualmeeting.html

**AOSSM Annual Meeting**
Seattle, Washington
www.sportsmed.org

**APMA Annual Scientific Conference**
Honolulu, Hawaii
www.apma.org

**International Association for Identification**
Minneapolis, Minnesota
www.theiai.org

**September 11-14**

**Ontario Podiatric Medical Association Annual Conference**
Toronto, Ontario
www.opma.ca

**October 18**

**Orthotic Technology Forum**
Eindhoven, The Netherlands
www.orthotic-technology-forum.com

**October 18-19**

**National Congress of Podiatry**
Docks of Paris, Porte de la Chapelle
fed.nationale.podologues@wanadoo.fr

**October 19**

**NVvP Annual Conference**
Eindhoven, The Netherlands
www.podotherapie.nl

**November 13-15**

**SCP Annual Conference**
Bournemouth, U.K.
www.feetforlife.org

**November 14-16**

**Live Well With Diabetes**
Sheraton Wall Center
Vancouver, British Columbia
www.foothealth.ca

**2015**

**March 19-21**

**DFCon Diabetes Conference**
Hollywood, California
www.dfcon.com

**July 23-26**

**APMA Annual Scientific Conference**
Orlando, Florida
www.apma.org

**2016**

**May 26-28**

**FIP World Congress of Podiatry**
Montreal, Quebec
www.fipworldcongress.org

**July 14-17**

**APMA Annual Scientific Conference**
Philadelphia, Pennsylvania
www.apma.org

**August 7-13**

**International Association for Identification**
Cincinnati, Ohio
www.theiai.org

**2017**

**International Association for Identification**
Atlanta, Georgia
www.theiai.org

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**Special Olympics**

The Special Olympics European Summer Games will be organized in Belgium (Antwerp) next September. Athletes from 58 countries will compete in Antwerp from September 13-20, 2014. There will be guests in the host town from September 9-13.

The Healthy Athletes Program with the Fit Feet program will screen athletes from September 13-20 in the Antwerp Expo. Information can be found on www.SO2014.com

Professionals interested in participating as screeners or becoming trained as Fit Feet Managers can contact their local Fit Feet manager or the regional advisor for Fit Feet in Europe/Eurasia – carine.haemels@skynet.be
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