Volume 19 Number 5 | **May 2016**

# PODIATRY NOW

The Society of Chiropodists and Podiatrists | The College of Podiatry



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# FEET FOR LIFE MONTH

## Next month we welcome Feet for Life Month 2016. Here is what it is all about and how you can get involved with our 'Step in to Action' tour

**Following on from last year's highly successful theme around walking, our plans for this year's Feet for Life Month in June are going to be bigger than ever before! The theme is 'fit feet' and our aim is to make sure everyone - in the street, on social media and in the press - is walking and talking about podiatry and the excellent work that podiatrists do to keep our feet in good health. And, we would really like you to be part of this year's campaign! Here's how**.

New for 2016 is the exciting introduction of a 'Step into Action Tour'. This will take place during Feet for Life Month where the aim is to take 'podiatry on the road' and engage directly with consumers across the country.

To make this happen 'with a bang' we would really like as many podiatrists as possible to join us in setting up one-day clinics in local gyms, golf clubs, libraries and health clubs to offer free foot health checks.

The Step into Action Tour will be in addition to the traditional Feet for Life activity and media toolkit, which outlines ideas for you to try in your local area to help spread the foot health message and encourage people to visit their local chiropodist or podiatrist.

When you sign up to the tour, we will support your local 'Step into Action' event by making as much noise as possible about Feet for Life Month and the tours by:

- A nationwide consumer PR campaign
- Securing local media coverage to promote the regional foot health checks
- Inviting local media to attend the free foot check and / or where needed take a podiatrist to the journalist / broadcaster
- Supporting the local events on social media by carrying out tweeting via the @SCP_podiatryUK feed to highlight the whereabouts of the podiatrists in advance of the events
- Attending a selection of the one day clinics to carry out live tweeting and 1-1 media outreach

**ADAM THOMAS**
**DIRECTOR OF MARKETING**

Our aim with the 'Step into Action Tour' is to literally put podiatry on the map, to extend the reach and engagement directly with consumers, and to offer you a unique platform and opportunity to promote your practice.

If you would like to be part of our 'Step into Action Tour', please contact Louise Everett on 0118 9475956 or email collegeofpodiatry@ceres-pr.co.uk for more details also please go to the members area of our website **www.scpod.org** for further details and updates.

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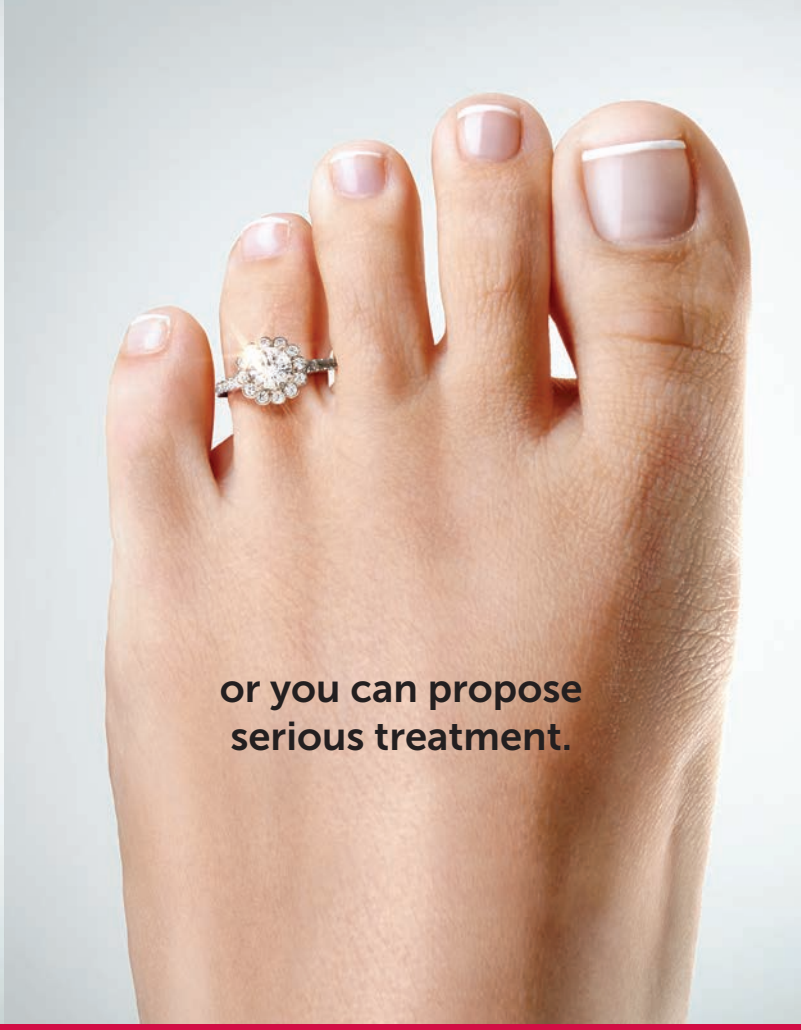



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# NEWS

## NUI GALWAY RESEARCHER WINS INTERNATIONAL WOUND CARE AWARD

**Andrea Mahon, a PhD student, in the Discipline of Podiatric Medicine, NUI Galway, was recently awarded a prestigious Journal of Wound Care Award for The Best Laboratory/ Pre-Clinical Study. This achievement was in recognition of research undertaken in fulfillment of her Masters by Research degree. Andrea fought off stiff completion to receive first prize in this category at the recent Journal of Wound Care Awards 2016 ceremony, held at The Banking Hall, London.**

To address the need for advanced wound therapies, Andrea designed a preclinical study to assess topical stem cell therapy in a diabetic animal wound model. A stem cell clinical trial in diabetic foot ulcers will be planned by the outcome of this research.

Andrea's research was supervised by Professor Caroline McIntosh, Head of Discipline of Podiatric Medicine, Professor Timothy O' Brien, Dean of the College of Medicine, Nursing & Health Sciences and Dr. Claire MacGilchrist, Lecturer in Podiatric Medicine. The Journal of Wound Care awards 'recognise innovation and excellence in research and practice' within the field of wound care. Their aim is to recognise individuals and teams who have improved, implemented or excelled in some field of wound care.

According to Prof. Caroline McIntosh *'This is a fabulous achievement which highlights the high quality of research being undertaken in wound healing and tissue repair at NUI Galway. Diabetes is one of the leading causes of lower-limb ulceration and amputation. Diabetes related foot ulcers are challenging to manage with many failing to respond to standard wound therapies. There is a need to research advanced therapies for application on non-healing wounds. The findings of Andrea's research will help in the design of first in human studies of mesenchymal stem cell application for non-healing neuropathic diabetic foot ulcers.'*

## SCP NEWS - PROGRESS REPORT ON PODIATRIC SURGERY AND HCPC ANNOTATION

**At its meeting on 4 March 2016, the College of Podiatry Academic Board (CoPAB) expressed the College's commitment to the future of podiatric surgery training, and agreed next steps, as follows.**

- Since the meeting of the Finance and Establishment Committee in November 2015, a number of Healthcare Environment Inspectorates (HEIs) have expressed interest in providing training to meet the HCPC standards, which will enable suitably qualified people gain the HCPC annotation.
- Thus far two HEIs in England have expressed such interest and one has put this in writing.
- The annotation working party will be invited to attend a validation event with a team from the Quality Assurance Committee (QAC). Through that event the College-designed programme will be refined with the aim of bringing it to a level compatible with the documentation standards of the Schools of Podiatry in the university sector.
- The HCPC will be informed of our intention to work with HEIs as an accrediting body (which is the way we work in pre-registration training), so as to assure the HCPC that there will be a structure in place that will enable qualified podiatric surgeons to gain annotation.
- The HCPC requires all providers to have procedures to accredit prior learning. This will provide opportunity for existing practitioners to gain the annotation. The College is mindful of the needs of our registered trainees and will take all reasonable steps to ensure they have opportunity to gain the annotation.

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## PODIATRIST HELPS STEER THE LIFE FOUNDATION

**Podiatrist Sophie Brewer (left) has been appointed to the management committee of The Life Foundation. This is the first time the charitable organisation has selected a podiatrist as a committee member.**

The Life Foundation's mission is to enhance the well-being of people living in challenging conditions and empower them through friendship, education and therapeutic services delivered by volunteers. Much of their work is with disabled children and adults living in state care in Romania and India. The Life team have over a decade of experience in recruiting and training volunteers of all ages and backgrounds to work overseas for short or long term placements.

Sophie first became involved after successfully applying to be part of a varied specialist team - she become the first podiatrist to volunteer with the project in the Oltenia region of Romania. Her trip was sponsored by Cosyfeet after she won the Cosyfeet Podiatry Award in 2015, enabling her to take stocks of podiatry supplies with her to assist in her work.

*'The Life Foundation is an inspirational team, truly driven to make a real difference to its beneficiaries,'* says Sophie. *'I'm so looking forward to being a part of that and helping attract volunteers to carry on and expand the amazing work that they do.'*

The Life Foundation aims to enable its volunteers to have a real and lasting impact on its beneficiaries, as well as providing volunteers with career developing and life-changing experiences. It attracts many returning volunteers and is reliant on a large volunteer network to progress its overseas work in India and Romania.

If you would like to find out more about volunteering with The Life Foundation see **www.thelifefoundation.co.uk**


## UEL STAFF AND STUDENTS BACK 'SHOES FOR SYRIANS' CAMPAIGN

**Staff and students at the University of East London (UEL) have donated an impressive 600 pairs of shoes following a University-wide 'Shoes for Syrians' appeal to help the plight of refugees fleeing the atrocities of ISIS.**

Graduate School academic Dr Ruqiyabi Naz Awan invited staff and students to donate comfortable shoes and trainers, which have already been flown out to the Greek island of Samos by her brother, Shakir, as part of a humanitarian convoy organised by the charity Lifeline Help. The island is currently home to thousands of refugees.

Naz said the response to the appeal was 'truly amazing', particularly as staff and students only had five days to donate. The resulting footwear haul included a number of pairs of brand-new trainers, which some generous donors had purchased specially for the campaign.

So many shoes were collected that a proportion have been passed onto Greenwich Refugee Aid Clothing and Essentials, who will be taking much-needed clothes and shoes to five cities in Syria this month.

Naz explained that her brother had been moved by the suffering of refugees and wanted to do something to help.

*'It all started when my brother was on Facebook and he discovered there were lots of ordinary people who just wanted to help, to do something,'* she said. *'People started talking to each on online, and it went from there.'*

Shakir soon found himself taking part in humanitarian convoy trips to the Keleti train station in Hungry, as well as Samos. The experiences have made a lasting impression on him and spurred him on to do even more.

As well the shoe campaign, the Awan family have been involved in raising money for the refugees. Younger family members, including Naz's five-year-old niece, took part in a sponsored swim at the start of February, raising £1,000.

The family have also invested some of their own money. They are paying for all of their own flights, accommodation and meals, which means all money donated goes directly to buy necessities for refugees.

Shakir flew out to Greece accompanied by his 11-year-son and hundreds of shoes packed into suitcases and sent regular texts, photos, and video updates of his journey to supporters and members of staff at UEL.

He plans to return to Samos and camps in France later in the year with others members of his family, including Naz.

Notes: Photos: 'shoepic' is Naz and Shakir on campus next to a pile of shoes donated by UEL staff and students. 'Airport' shows Shakir with his son and some of the suitcases filled with shoes and trainers. 'Plane' shows Shakir and son about to board the plane. Please credit Dan Blackman/UEL.

If you'd like to arrange an interview with Naz or Shakir please get in touch with me **D.Blackman@uel.ac.uk 0208 223 2701** or **07894 800 512.**

## MESSAGE TO MEMBERS FROM THE ADMISSION TUTORS FORUM

# STUDENT RECRUITMENT
## THE FUTURE OF THE PROFESSION IN PERIL

**Recruiting students onto undergraduate podiatry programmes is difficult. Currently we have about three applicants per place, meaning that there is very little competition for places and that each of the schools of podiatry are competing against each other for the best candidates. We know there is no shortage of people wanting to do medical courses because physiotherapy, occupational therapy and midwifery programmes for example are hugely oversubscribed. Currently podiatry has one of the lowest application rates of all healthcare degrees, which has huge negative implications for the future of each of the podiatry programmes, the Society, the profession, our patients and Government.**

To this end Council has established a short-term working group to look at the problems of recruiting new undergraduates into the profession of podiatry. The purpose of this article is to highlight the severity of the situation, explain the work that has been done and hopefully demonstrate the positive impact this will have on you and the profession as a whole in the months and years to come.

The training of each podiatry undergraduate currently costs in excess of £10,000 per student per year. With the loss of NHS funding, and no decision made as to funding in the future, universities are quite rightly going to start looking at the financial viability of these courses. For podiatry this is compounded further by the facts that:

- Courses struggling to recruit are under pressure to take students with lower grades, some of whom don't stay the course
- Most courses have to go into clearing to fill the last few places

Both of these negatively impact on the universities' standing in the national league tables, something that most business savvy institutions won't tolerate for long.

If universities start cutting programmes we could see a drastic reduction across the UK in the number of podiatrists graduating each year. With a growing and aging population, if the numbers coming into the profession fall behind the numbers leaving the profession, very soon the provision of podiatric care will not meet a growing demand.

This is bad news for the profession, the Society, the public purse and society as a whole.

In line with last year's members survey and one published by Algeos, the working group and we agree that a big part of the problem with recruiting undergraduates is a lack of awareness and understanding of podiatry amongst the general public. The working group has therefore proposed and submitted for approval, short and long term marketing projects aimed at raising awareness of podiatry across the UK.

The working group consulted with a number of key stake holders in order to come up with the proposed plan.

The way the university application cycle works means we need to deliver an intensive campaign very quickly in order to boost applications for the 2017 intake. The working group feels the only way to do this and still deliver a quality campaign, is to focus all attention around the schools of podiatry and help each one boost their own local marketing activity. We are hugely supportive of this initiative as are the programme leads and we want to call on members to support it too.

This local campaign is going to draw on alumni of each of the podiatry schools, people who have positively influenced current students, and local branches and NHS departments to help spread the word about podiatry as a great career choice. This will be combined with local and national media coverage, online and advertising activity.

So far this project has been approved by the Society's Strategic Planning Board and the final hurdle is to gain financial approval before we can launch the campaign.

If we gain that approval please watch out in your mail, because you may be the recipient of a letter from your old or local school of podiatry asking you to join in and help us spread the word about the benefits of choosing a career in podiatry. We would obviously be very grateful for your support and enthusiasm in this regard.

We will work hard promoting podiatry amongst our local communities but we also know that practitioners can play a key role too, so we will support you as well in spreading the word about the benefits of podiatry as a great career choice.

The working group is also proposing a longer term UK wide marketing campaign aimed at raising awareness and understanding of podiatry. The objectives will be to increase the foot fall into practices, improve appropriate and timely referral, influence decision and policy makers, clarify foot care provision uncertainty and raise the standing of the profession on a national level. All of this will hopefully lead to an increase in the number of people applying to study podiatry.

Though this is still only a concept on paper that has yet to be presented for strategic and financial approval, we want to encourage as many members as possible to show their support for this initiative by getting in touch and letting us have your comments, questions and suggestions. The more the merrier.

Please visit the website below to let us have your thoughts.

**SCPOD.ORG/BLOG/STUDENT-RECRUITMENT**

## UNION LEARNING FUND PROJECT PODIATRY ASSISTANTS WORKSHOPS

**ANNA LUNATO, ULF PROJECT WORKER SOUTH EAST, EAST OF ENGLAND & EAST MIDLANDS**

**Two events for podiatry assistants were held in the autumn of 2015. The workshops included an update on 'Talent for Care,' a session on Getting the most out of your Appraisal and a workshop on Mental Health Awareness.**

Liz Salem, ULF Project Manager, started the day with an update on Talent for Care and explained the strategies behind the three stages of Health Education England (HEE). She then went on to explain the Partnership Pledge. This pledge has been brought about by HEE in order to get Local Education and Training Boards (LETBs), employers and trade unions to work together to develop and support training and career progression for those working in bands 1-4. HEE has put together an exemplar action plan which can be viewed at: **http://hee.nhs.uk/wp-content/blogs.dir/321/files/2015/08/Local-Partnership-Pledge-Action-Plan-and-Implementation-Tool.pdf**

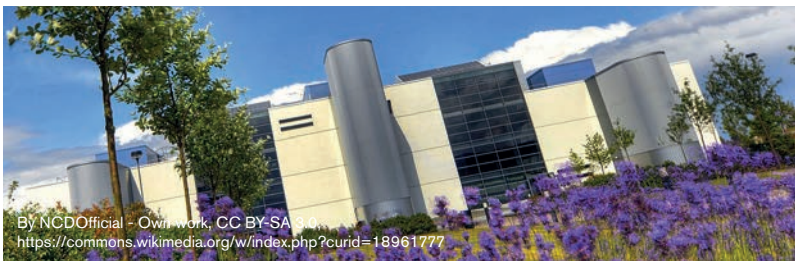
Sandra Edwards, ULF Project Worker for the north of England, then took the session on Getting the most out of your Appraisal. She started by defining the core elements of an appraisal: a review to discuss performance, training and the planning of personal development. She emphasised the importance of planning ahead for an appraisal and being aware of broader organisational objectives as well as focusing on personal needs and aspirations. Part of the process should include a self-assessment whereby the appraisee analyses whether they have, for example, received the right training for the role they are undertaking, and an assessment of their own performance by listing achievements and successes. Successes should be evidenced and appraisees should refer to their CPD portfolio to back up statements. Sandra then got the assistants to undertake a SMART assessment so that they could list issues, and achievements in preparation for their interview.

The last session of the day was on Mental Health Awareness, led by Karen Reed, ULF Project Worker for the South West & West Midlands. The assistants explored the difference between good mental health and mental ill health, and the impact of poor mental health on themselves, service users and the community as a whole. They listed some of the symptoms of mental health conditions and Karen made the group aware of legislation to help members, service users and those affected by mental health issues. The group then went on to discuss stress and its effect in the workplace.

The ULF Project team would like to thank ULRs and Union Reps for promoting these events to the assistants. To view presentations from the events and details of other past events held for podiatry assistants please follow this link: **http://bit.ly/1ZjyqLz**. To find out more about Talent for Care please follow this link: **http://bit.ly/22rMiJ4**

To find out more information about the Partnership Pledge please follow this link: **http://bit.ly/1pvqeuZ**

To access a resource on Mental Health Awareness produced by the TUC please follow this link: **http://bit.ly/1o1eRKf**



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## NEW COLLEGE DURHAM ADVANCED APPRENTICESHIP PROGRAMME FOR PODIATRY ASSISTANTS UPDATE

**On a recent visit to New College Durham, ULF Projector Worker Anna Lunato caught up with Claire Kelly and Keith Forster for an update on the new Advanced Apprenticeship Programme for Podiatry Assistants**

Eight podiatry assistants are undertaking the Advanced Podiatry Assistant Apprenticeship programme, which started at New College Durham on 25th September. The programme runs for just over a year and combines workplace learning with classroom based theory, portfolio building and underpinning knowledge.

The apprentices attend the College for one day a week. The day is split between gaining clinical knowledge and undertaking functional skills training in maths and English. The apprentices also benefit from observing podiatry students at the College. The remainder of the week is spent in the workplace, allowing the apprentices to gain practical clinical experience. To achieve the Level 3 Diploma, the podiatry assistants will need to achieve a minimum of 65 credits, from a suite of suitable units. The units will be assessed by experienced occupational competent assessors through the use of observations in the workplace, written and oral questions and professional discussions. The apprentices collect a portfolio of evidence to prove competence against the criteria of occupational standards.

It was initially thought that the programme would attract podiatry assistants predominantly from the NHS, however half of the apprentices undertaking the Advanced Apprenticeship are currently employed in private practice. Claire Kelly, Curriculum Manager, explained that the Advanced Apprenticeship Programme has a progress review system in place which enables a three-way process whereby the College, apprentices and the employer can feed back information regarding the programme. This is undertaken every quarter to make sure all parties are satisfied with the training provided and that everything is on target.

Claire Kelly said that the apprentices are dedicated, eager to learn and enthusiastic about the course. One Podiatry Assistant Apprentice remarked *'I have found the combination of workplace learning and study at the College very interesting and I am able to link the two together'.* An apprentice has also been motivated to apply for a place on the podiatry degree course at the College.

This route into higher education via an Apprenticeship may well provide a solution to the current, worryingly low take up of places on podiatry degree programmes, which will be exacerbated following the removal of the bursaries in 2017. Employers are also finding the course beneficial and particularly like the progress review process as they can communicate to the College about specific areas in which they feel the assistants require training, said Keith Forster, Advanced Curriculum Manager.

Due to the success of the Advanced Apprenticeship Programme, New College Durham have received a lot of enquiries from podiatry assistants and employers and therefore will be exploring putting on an extra programme commencing at Easter, in addition to the yearly course starting in September.

New College Durham is still one of the few colleges who are exploring Apprenticeship programmes for podiatry assistants, so it is great news that they are proving to be so popular. With the government push on Apprenticeships, more Trusts and private practitioners need to explore the Apprenticeship route for training and in turn Colleges will need to adapt and recognise that Apprenticeships are valuable and meaningful ways of training people for employment and career progression.

To find out more about the Apprenticeship Programme at New College Durham please visit: **http://bit.ly/1Uxao02** or contact Claire Kelly at **claire.kelly@newdur.ac.uk** or Keith Forster at **keith.forster@newdur.ac.uk**

# HCPC LAUNCHES CONSULTATION ON THE NAMES OF MEDICINES ANNOTATIONS FOR CHIROPODISTS / PODIATRISTS

**The Health and Care Professions Council (HCPC) has today launched a consultation to seek the views of stakeholders on renaming the 'local anaesthetics' and 'prescription only medicines' annotations for chiropodists / podiatrists. This will ensure they more closely reflect both exemptions in medicines legislation.**

Chiropodists / podiatrists who have undertaken approved training are annotated (marked) on the HCPC Register. This indicates their ability to sell or supply (the 'prescription only medicines' annotation) and/or administer (the 'local anaesthetics' annotation) certain medicines from exemption lists in medicines legislation.

However, the current way in which these annotations are labelled is out of date. For example, the exemption list that relates to the 'local anaesthetics' annotation now includes other medicines, and the medicines on both lists are 'prescription only'.

Michael Guthrie, Director of HCPC Policy and Standards, commented: *'We are proposing that each of the annotations should be renamed for clarity, with the 'prescription only medicines' annotation becoming 'medicine – sale / supply.'* The other proposal would be that the 'local anaesthetics' annotation would become 'medicines – administration'.

*'We welcome feedback from all our stakeholders. This consultation may be of particular interest to registrants, education providers and professional bodies. The HCPC will analyse the responses once the consultation closes, publish the comments received and explain the decisions made as a result.'*

The consultation only runs until **3rd May 2016**, so be quick. To take part please visit **www.hcpc-uk.org/aboutus/consultations**, email **consultation@hcpc-uk.org** or write to **Consultation on renaming the 'local anaesthetics' and 'prescription only medicines' annotations for chiropodists / podiatrists, Policy and Standards Department, Health and Care Professions Council, Park House, 184 Kennington Park Road, London SE11 4BU.**

## STATEMENT FROM THE COLLEGE OF PODIATRY

Members will be aware that the Health and Care Professions Council is currently undertaking a consultation on a proposal to change the names of the medicines annotations for chiropodists/podiatrists that appear on the HCPC register. The College of Podiatry supports these proposals, and, in fact, first raised the issue with the HCPC in a bid to effect a change in the names of the medicines annotations. There were two key reasons to doing so. First, the names of two of our medicines annotations ('Local anaesthetics' and 'Prescription only medicines') no longer accurately reflect the medicines on the lists available to podiatrists. Medicines listed under the annotation entitled 'local anaesthetics', for example, contain not only local anaesthetic agents, but other medicines, such as methylprednisolone and adrenaline. This is because the medicines on this list are actually those available for use by podiatrists by administration only. We 'administer' local anaesthetics, methylprednisolone and adrenaline, generally by injection, but we do not sell or supply them our patients. Equally, these medicines are all prescription only medicines, yet we have a separate annotation entitled 'prescription only medicines'. Clearly, this is confusing and unhelpful for anyone seeking to consult the lists.

In order to clarify the issue, it is important we understand which medicines the annotations permit us to access and use. The two annotations enable us to access and use medicines on two separate lists – a list for sale and supply, and a list for administration. Our 'local anaesthetics' annotation allows us access to medicines on the 'administration list'. That list includes local anaesthetics, but also includes methylprednisolone and adrenaline, which are not local anaesthetics. What they share in common is that they are available for use by administration. We cannot sell them or supply them to patients, but we can administer them.

Our second annotation, entitled 'prescription only medicines' refers to a list of medicines that we may access for sale and supply to patients. All the medicines on that list are prescription only medicines, but so too are all the medicines on the 'local anaesthetic' annotation.

A relatively simple change to the titles of the two annotations should solve the problem quickly. Re-naming the annotation 'local anaesthetics' as 'medicines – administration' immediately makes it clear that the annotation refers to the list of medicines available to podiatrists for administration. Similarly, renaming the annotation 'prescription only medicines' as 'medicines – sale and supply' makes it immediately clear that it refers to the list of medicines available to podiatrists for sale and supply.

To do so directly links the annotations to the lists of medicines to which they refer. Each of these lists is available to view in the Human Medicines Regulations (2012), pages 236 (sale and supply) and 239 (administration), which may also be viewed via the webpages: www.legislation.gov.uk/uksi/2012/1916/schedule/17/made

**Mr Matthew Fitzpatrick and Dr Alan Borthwick**
**College of Podiatry**
**17th March 2016**

## Directorate of Podiatric Medicine
## 5th Annual Podiatric Sports Medicine Conference in Association with European College of Sports and Exercise Physicians

### "Inspiring Clinical Excellence - Thinking Beyond Biomechanics"

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The Royal College of Surgeons of England, London
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AESCULAP ACADEMIA

E.C.O.S.E.P.

# MSK SPECIAL

**JILL HALSTEAD**
**CO-FOUNDER**
**MSK:UK**

**EMMA COWLEY**
**CO-FOUNDER**
**MSK:UK**

**The editorial committee and MSK:UK (the musculoskeletal special advisory group affiliated to the College of Podiatry) have come together to produce, what we hope will be, an interesting special musculoskeletal edition.**

Musculoskeletal pains in the foot and ankle are a common cause of disability, particularly in middle to older age groups. It is the reason why many of our patients seek help and relief from symptoms.

One of the main challenges facing our profession is to provide safe and effective treatments for joint and soft-tissue pains in the foot and ankle. Not only do we need to show patient benefit, we also need to understand the how our treatments work.

For this edition we have invited a wide variety of authors from home-grown and international podiatrists with clinical and research expertise in musculoskeletal conditions. We have included big picture articles like, 'Foot pain - what are the big issues?' and 'What has research taught us about foot and ankle conditions in the last 10 years?'. We also included articles to inform our core practice 'Paradigms of foot and ankle function' and 'How do foot orthoses work?'. There are also topical articles around new emerging treatments, such as taping and manual therapies. Finally, possibly the most important issue is addressed: 'What is the impact of our profession in musculoskeletal conditions?'.

In line with MSK:UK's main aims, we hope this edition will be enjoyable and inform your clinical knowledge.

**Co-founders MSK:UK Dr Jill Halstead and Emma Cowley**

Join the debate at:

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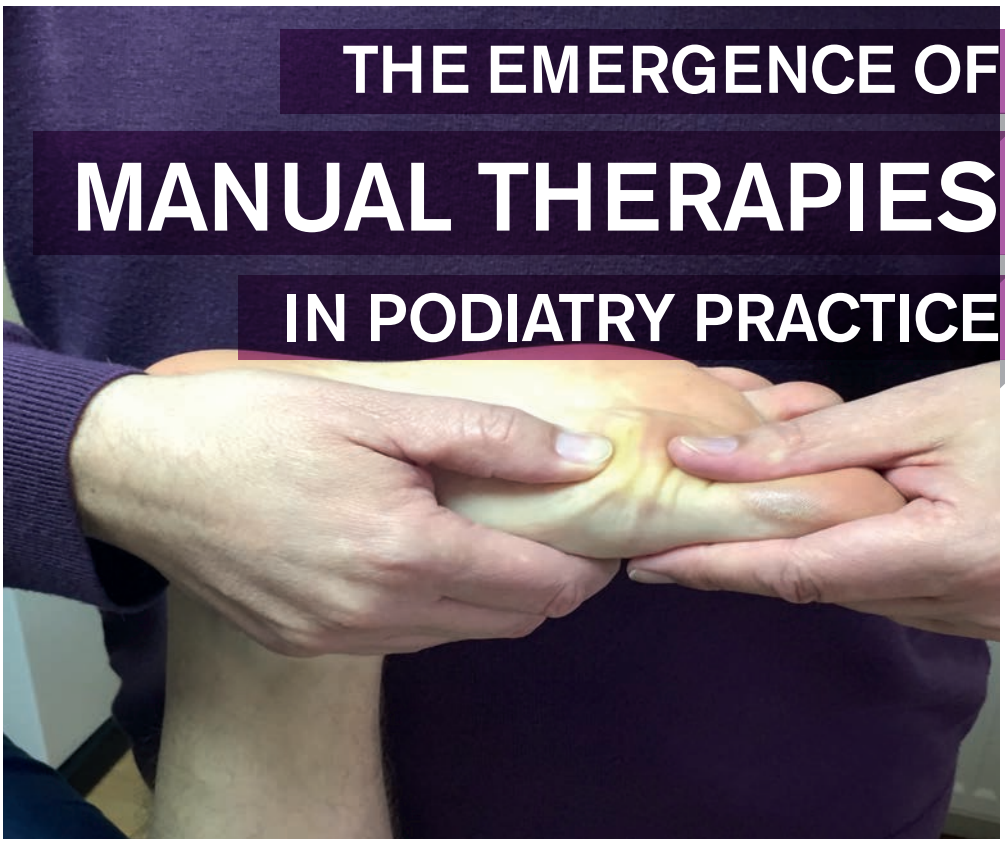
MSK:UK

# THE EMERGENCE OF MANUAL THERAPIES IN PODIATRY PRACTICE

MSK SPECIAL



Podiatric interest in manual therapy and rehabilitation is undergoing a resurgence. This is at a time when our understanding of joint motion, functional rehabilitation/ exercise and appreciation of injurious affects upon neuromuscular function, within the low limb, is increasing.

## What is manual therapy?

Manual Therapy (MT) has been defined as:

*'Skilled hand movements intended to do any or all of the following: improve tissue extensibility; increase range of motion of the joint complex; mobilise or manipulate soft tissues and joints; induce relaxation; change muscle function, modulate pain and reduce soft tissue swelling, inflammation or movement restriction.'* [1]

Within the allied health professions a variety of MT disciplines exist and includes physiotherapy, osteopathy, chiropractic and sports therapy. Each has significantly distinctive concepts and approaches yet increasingly share some common ground, with cross-fertilisation of concepts and techniques frequently occurring.

All such disciplines require practitioners undertake a detailed medical history, physical assessment of the quality and range of movement (QOM, ROM) of joints and soft-tissues, observe where inhibition of their healthy function may lie, or, where assessment tests evoke symptoms, they are required to apply careful skilled rehabilitating techniques.

## What is the role of MT podiatry?

Historically, in the 1950s, MT had a role in chiropody practice and though such skills have been largely lost to us some podiatric practitioners have continued to employ them. In more recent years some of our training schools are now including demonstration of such techniques within their MSK modules.

Podiatrists employing MT aim to restore QOM and ROM through application of a gentle, controlled, gliding force to the joint, moving one joint surface upon the other or, in the case of muscle, a careful application of massage force to tissues. The glide of a joint and tissue can be graded to determine the amount and direction of force applied. The intent of application is stimulation of the neuromuscular system, reduction of pain, restoration of pliability of tissue structures and capacity of those structures to tolerate mechanical loading again. Its resurgence is perhaps timely, as our understanding of foot function further evolves.

**IAN LINANE**
**PRIVATE PRACTICE PODIATRIST**

Lundgren et al,[2] and Nester et al[3,4] reported on kinematic measures of structures within the foot, demonstrating that motion between joints of the foot and ankle are greater than previously appreciated:

*'Our data reveals that the motion among the navicular, cuneiforms, cuboid and five metatarsals is likely to be of clinical significance and demonstrates that all these joints have an important role in the overall kinematic function of the foot.'* [3]

The differences in motion between individual joints and between the joints of individual feet led the authors to draw the following conclusion:

*'Rather than continue to apply a poorly founded model of foot type whose basis is to make all feet meet criteria for the mechanical 'ideal' or 'normal' foot, we should embrace variation between feet and identify it as an opportunity to develop patient-specific clinical models of foot function'* [3]

Given the above definition and description of MT, together with current perspectives on foot function, MT can be a significant contributor to the assessment and intervention of many cases that present in a podiatry clinic. These techniques are widely used in a post-traumatic model of the ankle following soft-tissue sprain and fracture[5] as well in addition to post-surgical care to prevent joint stiffness in the healing phase.[6]

A wider range of clinical examples are presented in the following case studies.

## CASE 1.

A mid 70s male demonstrating tissue viability concerns, not responding to orthotic therapy after 12 months, is exampled in Figures 1a and 1b. Treatment involved a short series combination of joint mobilisation and specific soft-tissue mobilisation.[7] The person now continues to wear orthotics (beneficially) post outcome. The use of

manual therapy in regards to the elderly has been shown to be beneficial in improving function (sit to stand etc),[8] and has also been posited to have a role in tissue viability concerns and improve outcomes in diabetes,[9] though more robust studies are required here.


Figure 1a


Figure 1b

## CASE 2.

An unusual forefoot presentation of seven years' duration, post a fractured hallux. Foot orthosis therapy had not resolved the positional hyper-extend hallux and digits, or the associated sesamoiditis due to adverse loading. A single session of joint mobilisation resulted in the change seen in Figures 2a and 2b and aided in resolving the sesamoiditis pain.


Figure 2a


Figure 2b

They no long wear orthoses but have changed some of their footwear types. This outcome is similar to post-surgical results where MT has been shown to reduce metatarsal joint restriction[10, 6]

## CASE 3.

A female in her early 60s with over 30 years of well-controlled rheumatoid arthritis (RA) who was experiencing increased limitation in ambulation is shown in Figure 3. Post a session of foot mobilisation she wrote suggesting: *'I am completely mobile, can go up on my 'tiptoes' (something I had not been able to do for 30 years) and now go down a flight of stairs without having to hold on to a bannister and do one step at a time.'*

MT is often used gently in osteoarthritic patients and with severe cases of inflammatory disease. Though a recent paper presented a pilot case on use of mobilisation in a patient with a hand injury,[11] evidence for its use in inflammatory arthropathies is minimal and there is no evidence for its use in the foot. This case would suggest it might have a role in rehabilitation where the disease is stable.

MT is not new to podiatry, having been undertaken by a small section of the profession over the years. It is not, however, afforded a significant part of undergraduate podiatric training, nor has it been built into a standard assessment/ treatment approach or been emphasised as a useful postgraduate training programme. Currently, it is undergoing a resurgence of interest and becoming more broadly practised and, with more robust studies arising, MT perhaps deserves a greater role in podiatric intervention than it has at present. ■


Figure 3

**Figure 1a:**
Pre-mobilisation:
- Complete loss of plantar fat pad.
- Rigid plantar flexed 1st ray.
- Dorsiflexed hallux at rest.
- Very tight 1st fascial slip.

**Figure 1b:**
Post mobilisation:
- Tension within the fascial slip has been reduced.
- Improved hallux position at rest.
- Improved ROM and QOM of the 1st ray.
- Reduced tissue viability risk.

**Figure 2a:**
Pre-joint mobilisation:
- The foot exhibits a marked plantar forefoot prominence,
- Elevation and retraction of the toes.
- This had been present for seven years post break to the hallux.

**Figure 2b:**
Post-mobilisation:
- The plantar prominence is reduced
- All toes in ground contact in both stance and gait.
- This was a single treatment aimed at stimulating afferent feed back to alter guarding and hopefully improving feed forward.

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# MANIPULATION OF THE FOOT AND ANKLE

## A REVIEW OF THE EVIDENCE BASE

MSK SPECIAL

### Introduction

The podiatric profession has shown an increasing interest in extremity manipulation in recent years. When this interest is considered alongside the drive to improve patient care through evidence-based practice, it is clearly appropriate at this juncture to consider the literature surrounding the intervention insofar as it relates to the foot and ankle. The clinician is compelled to ask the question 'Is there any scientific backing for the techniques employed when manipulating the extremities?' This article seeks to present current evidence regarding the efficacy of manipulation in the treatment of a number of common foot conditions and also to touch on the emerging science that explains the mechanisms by which manipulation impacts the body.

Although there is a growing body of evidence one must acknowledge that, in terms of the scientific method, foot and ankle manipulation is in its infancy. There are few randomised controlled trials (RCTs) to draw conclusions from, with a recent literature review identifying just 14.[1] There are however a plethora of controlled trials, reviews and case studies from which to glean information.

### Mechanisms of action

Evidence tells us that when the nervous system is subjected to new and unfamiliar input such as that resulting from injury, all subsequent input is processed and responded to differently, compared to the pre-injured state.[2-6] In other words, altered feedback to the central nervous system (CNS) leads to altered sensorimotor response, resulting in dysfunction.[7, 8] Because muscle recruitment patterns change in response to pain, we can find ourselves held in a self-perpetuating cycle of dysfunction [9, 10] where new muscle recruitment patterns change proprioceptive feedback, which in turn reinforces the altered patterns, all in an effort to avoid or minimise the pain experience. This results in the body maintaining the pain-induced dysfunction.

The extensive research of Haavik et al has shown that manipulation sends normative neurological feedback to the CNS and encourages more appropriate motor responses.[7, 8, 11-14] Research in this field demonstrates that appropriate manipulative intervention can improve proprioceptive function,[15] alter CNS communication and muscle response,[14, 16, 17] and increase muscle strength in the lower limb.[18] Manipulation loads the system with 'normative' data, which leads to a dampening of the dysfunctional response and a heightening of normal neurophysiological responses. We also now know that rapid thrust manipulation produces a neurophysiological change that is not seen in other types of manual therapy such as mobilisation or active stretching.[19, 20]

**DAVID CASHLEY**
**PODIATRIST, THE DUNDEE PODIATRY CLINIC**

**Left:** Mobilising the subtalar joint

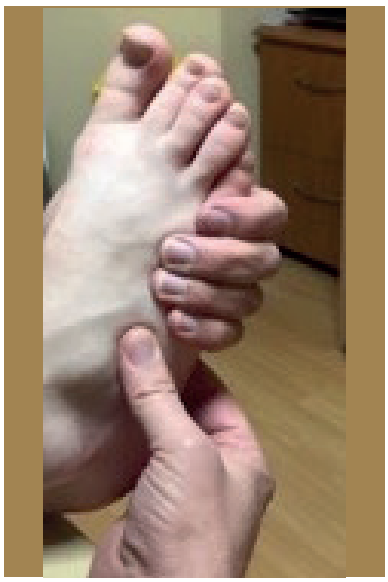
### Morton's Neuroma

Morton's neuroma (MN) is seen in almost every podiatric setting on a regular basis. The established treatments for MN leave room for improvement and there is research to suggest that manipulation may benefit sufferers. A recent retrospective study of 38 consecutive cases found a significant benefit from employing manipulation. In this study, the mean pre-treatment duration of pain was 28 months and the mean pre-treatment visual analogue pain scale (VAS) was 69.5/100 mm. By the sixth treatment, 30 (79%) patients scored a VAS of 0/100 mm and a further four (10%) were below 10/100 mm. There was also a significant linear trend between decreasing VAS and manipulation ($P < .001$), showing that manipulation was associated with decreased pain.[21]

Pain scores were also significantly improved in the manipulation group of another study when compared to detuned ultrasound.[22] In this controlled trial, Govender et al found a large favourable treatment effect.[22] There are a number of limitations with this study, including small sample numbers, potential researcher bias and potential subject expectation bias. Additionally, the follow-up in this study was very short, at just three weeks post treatment. That said, the results do suggest that the intervention is worth exploring further. Adding to these papers, there are a number of smaller case studies reporting good success in treating MN with manipulation,[23-26] More research is required in this field, but results so far are extremely promising.

### Ankle sprains

Ankle injuries are a common complaint in the MSK setting and recurrent injuries are not uncommon. Often these injuries occur in patients for whom



**Left:**
Mobilising the cuboid

sporting activity plays a significant role in their lives and therefore a timely recovery is of paramount importance. There is evidence that manipulation hastens the return to activity. A 2007 RCT was able to demonstrate that manipulation following an ankle injury resulted in redistribution of the foot load so that the post-manipulation foot was more stable.[27] This correlates with Grindstaff et al who established that manipulation of patients with chronic ankle instability resulted in improved muscle activation and neurological responses similar to those observed when using cryotherapy.[28] Another RCT also established that manipulation led to improved proprioceptive responses and increased ankle dorsiflexion.[29]

These findings contrast with a study which found that manipulation of asymptomatic ankles did not change loading.[30] Drawing these four studies together may allow a tentative suggestion that manipulation can affect progress toward normalisation of function. There are also a myriad of smaller studies that have shown manipulation to be beneficial in the treatment of ankle inversion sprains[31-39] suggesting that manipulation could justifiably be the first line of treatment for this condition. Pellow & Brantingham compared manipulation to placebo in an RCT and concluded *'Although both groups showed improvement, statistically significant differences in favour of the adjustment (manipulation) group were noted with respect to reduction in pain, increased ankle range of motion and ankle function'*.[31] Dananberg et al offered some quantification to this improvement when they demonstrated that manipulation gained almost 50% more dorsiflexion over a stretching programme after ankle injury.[40] Whittman et al were also able to add that 75% of ankle sprain patients would respond to manipulation within just two treatments, with no adverse events reported.[41]

This provides a brief overview of what is a vast amount of good literature in support of manual therapy to treat ankle inversion injuries, and podiatrists who are skilled in such techniques are well placed to provide such care.

## Plantar fasciitis

Ghaffor, Ahmad & Gondal[42] performed a randomised control trial of 60 subjects to examine whether manipulation was a useful adjunct when treating plantar fasciitis (PF) with physical therapy. They found that the manipulation group significantly out-performed the physical therapy only group and the authors therefore recommend manipulation when treating PF. Dimou also found that his manipulation group reduced their pain score more quickly than those in the orthoses group of his study, although both groups did improve.[43] This study was, however, severely hampered by the low sample size of just 10 subjects.[43] In a small case series, Young et al also report timely resolution of symptoms in response to manipulative intervention[44] and these results are replicated in a number of other case studies.[45-47] Wyatt reviewed 15 cases of sufferers who underwent manipulation after failed surgical interventions and reported excellent results in 11, good in three and poor in one.[48] So whilst there is some reporting of success within the literature, the evidence remains weak and one could not justify using manipulation alone as a primary intervention. However, it may well be considered useful in a multimodal approach and should certainly be considered in non-responsive cases.

## Hallux Rigidus

There is as yet no gold standard conservative intervention for Hallux rigidus (HR), but manipulation offers some hope for slowing the progress of this condition. The effectiveness of manipulation, combined with steroid injection for HR. has been addressed by Solan et al. They found that this was a beneficial approach in all but the very worst of cases, which tended to require surgery.[49] Brantingham also suggested that manipulation can be helpful when treating this condition.[50] His first report was a single case study of a professional golfer who was able to continue his profession without taking time out for surgery and recovery. He followed this with a small case series, again identifying the potential for significant gains from employing manipulation to treat this condition.[51] Manral also cites a single case to suggest that manipulation may have a place in the treatment of HR.[52]

Whilst the literature comprises almost entirely of single case series reports, there is a potential benefit in employing manipulation prior to opting for surgical intervention since it may afford the patient relief without the need for halting work and leisure activities whilst recovering. It must be stressed however that more robust research is required before any definite conclusions can be drawn.

## Conclusion

In conclusion, it is evident that there is a growing body of literature in support of lower-extremity manipulation, but there is a need for a greater number of RCTs into the various conditions that may benefit from this intervention. That said, there is certainly enough evidence to support the continued use of manipulation within the podiatric field.

The number of courses available to the profession validated through the College of Podiatry continues to grow and the evidence base would suggest that this may well be a string worth adding to your clinical bow. ■

> *"THE CLINICIAN IS COMPELLED TO ASK THE QUESTION 'IS THERE ANY SCIENTIFIC BACKING FOR THE TECHNIQUES EMPLOYED WHEN MANIPULATING THE EXTREMITIES?'*

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MSK SPECIAL

# KINESIOLOGY TAPING:

## DOES IT HAVE A PLACE IN PODIATRY?

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### Origins of Kinesiology Tape and the 'Olympic Effect'

Kinesiology tape was introduced in 1979 when Japanese chiropractor Dr Kenzo Kase developed Kinesio Tex Tape while he was searching for a new sports taping method that could assist in the healing of damaged tissue and muscles. Its use outside Asia began in the mid 90s but it remained relatively low profile until 2008 when Dr Kase allegedly gave tens of thousands of rolls of free tape to nearly 60 participating countries in the Beijing Olympics. Since then, other brands of kinesiology tape have been produced and are now available, such as Rocktape and SportTape.

The tape slowly began appearing on professional sportsmen and woman worldwide and then had a further high-profile boost during the London 2012 Olympic games where its widespread use was picked up by numerous journalists and it was even referred to by CNN as the 'latest Olympic accessory'.

None of this did the sales of all brands of kinesiology tape any harm of course, but quite rightly questions began to be asked regarding both its mechanism of action and whether it delivered on the claims that it made. A tape that promised to increase strength, increase range of motion, heal injured tissues, improve circulation (amongst other claims) certainly seemed too good to be true. Indeed, one brand found itself embroiled within a consumer fraud class action lawsuit[1] as a result of such claims.

So is there any evidence for its use or is it just a big colourful fad?

### The Evidence…

A comment heard regularly in discussions concerning kinesiology tape is that 'there is no research'. This is not the case. A PubMed search finds in excess of 150 articles published. Since 2012, 10 systematic reviews/meta-analyses (Level I evidence) have been published on Kinesiology tape. This again is likely due to the Olympic effect, and it is doubtful that so many studies of this type have been performed on any other topic within a similar time frame. Table 1 contains a summary of these papers.

A good editorial to read before considering the conclusions of these reviews was recently published in the British Journal of Sports Medicine.[2] To provide some podiatric context here, systematic reviews are only as good as the articles they include, and in the case of these 10 they include many papers that were not studying musculoskeletal injury and most were certainly not looking exclusively at use in the lower limb.

### Mechanism of Action

This is where much debate remains as the exact working mechanism of kinesiology tape remains unknown. One of the main proposed effects (anecdotally) is that the tape has an effect on muscle activity. A very recent study published by a team from Hong Kong Polytechnic University[3] did this theory no favours when it concluded that the tape has neither a facilitatory nor an inhibitory effect when applied to muscle (although this was performed on healthy participants and used in the upper limb).

Psychological effects can be powerful in professional athletes and it has certainly been labelled a placebo by many sceptics. It is not unreasonable to assume the colour of the tape (one of the main features immediately noticeable when worn by sportsmen and women on television) may have a role to play here. It is known in the world of pharmacology that the colour of drugs will have an influence on their effectiveness[4] so perhaps it is not a stretch to imagine how this could apply to kinesiology tape. There is also evidence showing that positive expectations can lead to pain relief with a variety of treatments[5,6] – in summary, if you expect pain relief you are likely to get it.

Although there is no supporting research, there is a growing belief that the main benefit of the tape may be due to the provision of a novel sensory input, which in turn results in a change of output (motor control and/or pain). Clearly, further investigation is needed.

### Kinesiology tape and common lower-extremity pathologies

Although there have been some suggestions that kinesiology tape may be worth considering in venous insufficiency[7,8] and also that it may improve pain and joint alignment (short term) in hallux valgus[9] the bulk of its use is primarily within the confines of the musculoskeletal and sports injury field. Lateral ankle issues and patellofemoral pain are well covered by recent systematic reviews, seen in Table 1 (overleaf). A cursory look over some of the other pathology specific research follows.

#### Plantar fascia symptoms

Tsai and colleagues[10] took 52

patients with 'plantar fasciitis' and gave half of them physical therapy only and the other half physical therapy and kinesiotaping. After one week, they found a significant reduction in both pain scores and plantar fascia thickness at its insertion site (assessed with ultrasound) in the group who had been taped. Lawson and colleagues[11] took 10 subjects with plantar fascia symptoms, took pain scores and imaged the plantar fascia after one week and three weeks of tape application. They also found a trend towards significant decreases in plantar fascia thickness and pain scores compared to baseline measures, but sadly did not include a control group for direct comparison. Although these studies are clearly very short term they do suggest there may be some merit in using kinesiology taping early on in cases of plantar fascia pain.

### Medial Tibial Stress Syndrome:

A recent study[12] took 20 healthy controls and 20 individuals with medial tibial stress syndrome and looked at their plantar pressure data after application of the tape. It suggested that kinesiotaping decreases the rate of medial plantar foot loading in patients with medial tibial stress syndrome. The inference here is that the tape decelerated pronation in pathological subjects. There were no suggestions as to the mechanism for this, nor any quantification of or comments on symptom modifications. Based on this study alone (there do not appear to have been any other published) it is difficult to conclude that kinesiology tape is a priority in managing medial tibial stress syndrome.

### Achilles Tendinopathy:

In 2010, a study[13] investigated the effects of kinesiotape on hop distance and pain in people with and without Achilles tendinopathy. The authors found no difference in either parameter between the groups and concluded that the use of the tape could not be supported for this condition. The following year a case report was published documenting a FIVE-week period of kinesiotaping for Achilles tendon pain in a badminton player.[14] It reported that over this period tendon thickness was reduced, ankle range increased and pain scores improved. Case reports are a relatively low level of evidence so these results should be considered in this context.

There is a dearth of published work looking at kinesiology taping for Achilles tendinopathy otherwise and as such it is difficult to recommend it for this pathology at this time.

**TABLE 1 - showing level 1 evidence (systematic reviews) since the Olympics**

| Reference | Number of included studies (mm) | Conclusions |
|---|---|---|
| Mostafavifar, M, Wertz, J, Borchers, J. A systematic review of the effectiveness of kinesio taping for musculoskeletal injury. *The Physician and Sportsmedicine* 2012; 40(4): 33-40. | 6 | Insufficient evidence to support use of tape following musculoskeletal injury but perceived benefit cannot be discounted. |
| Williams, S, Whatman, C, Hume, PA, Sheerin, K. Kinesio taping in treatment and prevention of sports injuries: a meta-analysis of the evidence for its effectiveness. *Sports Medicine* 2012; 42(2): 153-164. | 10 | Little quality evidence to support use but the amount of case study and anecdotal support warrants well designed experimental research. |
| Kalron, A, Bar-Sela, S. A systematic review of the effectiveness of Kinesio Taping – fact or fashion? *European Journal of Physical and Rehabilitation Medicine* 2013; 49: 1-11. | 12 | Immediate reduction in pain for musculoskeletal disorders but no evidence for use in neurological conditions or for increases in strength/ range of motion. |
| Morris, D, Jones, D, Ryan, H, Ryan, G. The clinical effects of KinesioTex taping: a systematic review. *Physiotherapy Theory and Practice: An International Journal of Physiotherapy* 2013; 29(4): 259-270. | 8 | Insufficient evidence to support use of tape over other modalities. |
| Montalvo, AM, Le Cara, E, Myer, G.D. Effect of kinesiology taping on pain in individuals with musculoskeletal injuries: systematic review and meta-analysis. *The Physician and Sportsmedicine* 2014; 42(2): 48-57. | 13 | No reduction in specific pain measures related to musculoskeletal injury investigated. May be used in conjunction with traditional therapies. Further research needed. |
| Parreira, PCS, Costa, LCM, Junior, LCH, Lopes, AD, Costa, LOP. Current evidence does not support the use of Kinesio Taping in clinical practice: a systematic review. *Journal Of Physiotherapy* 2014; 60(1): 31-39. | 12 | Current evidence does not support using this intervention in the clinical populations that were investigated. |
| Csapo, R, Alegre, LM. Effects of Kinesio Taping on skeletal muscle strength – A meta-analysis of current evidence. *Journal of Science and Medicine in Sport* 2015; 18(4): 450-456. | 19 | The potential for tape to increase strength is negligible. May be some therapeutic benefits but usage does not promote strength gains. |
| Lim, ECW, Tay, MGX. Kinesio taping in musculoskeletal pain and disability that lasts for more than 4 weeks: is it time to peel off the tape and throw it out with the sweat? A systematic review with meta-analysis focused on pain and also methods of tape application. *British Journal of Sports Medicine* 2015. 0, 1-10, doi: 10.1136/ bjsports-2014-094151. | 17 | Superior pain relief compared to minimal intervention but the superiority of taping over other approached not established. |
| Wilson, B, Bialocerkowski, A. The effects of kinesiotape applied to the lateral aspect of the ankle: relevance to ankle sprains – a systematic review. *PLoS ONE* 2015. 10(6), doi: 10.1371/journal.pone.0124214. | 8 | May have role in preventing lateral ankle sprains but unlikely to provide sufficient mechanical support to improve postural control in unstable ankles. |
| Chang, WD, Chen, FC, Lee, CL, Lin, HY, Lai, PT. Effects of Kinesio Taping versus McConnell Taping for patellofemoral pain syndrome: a systematic review and meta-analysis. *Evidence-Based Complementary and Alternative Medicine* 2015. http://dx.doi.org/10.1155/2015/471208 | 11 | Kinesiotaping can improve pain and quality of life but not change patella alignment. |

## Are there risks associated with Kinesiology taping?

When compared to more traditional taping, kinesiology tape is easier to apply (for both practitioner and athlete alike), generally stays in situ for longer and is more resistant to water. The incidence of allergy is unknown but thought to be low. Bicici and colleagues[15] found that whilst executing numerous functional performance tests kinesiotape had no negative effects compared to traditional athletic tape, and even showed improvements in some of the tests. Therefore, there appears to be little harm in using the tape with a general belief being that the worst it may do is have no benefit.

However, our current understanding of pain is that it is a perception and that this perception is produced by the brain in response to perceived threat or danger,[16] We therefore have to be careful in both the interventions we apply and the language we use to describe them to ensure we do not instil a sense of fragility or vulnerability in our athletes or patients, as this may actually increase the brains output of pain and would clearly be problematic in the long term.

## Conclusion

Very little high-quality evidence for the use of kinesiology tape exists. It does appear to be able to influence pain, but the mechanism by which it achieves this is unclear. What is clear is that more research is warranted, particularly given the claims made regarding potential benefits and the increasingly widespread use amongst professional and amateur sports participants.

With respect to lower extremity pathology specifically, it may have a beneficial short-term role (as part of a multi-modal rehabilitation strategy) in cases of plantar fascia pain, symptomatic hallux valgus and anterior knee pain. It may have a preventative role to play regarding ankle sprains, but this is unlikely to be the case in those with already unstable ankles. ■



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MSK SPECIAL

# FOOT FUNCTION THEORIES OR PARADIGMS: A QUANDRY

**When evaluating foot function 'theories' we should consider how each explanation has been able to stand up to scientific research. English is a traitorous language, where words often have two meanings. Sadly 'theory' is one of these, with both a common English meaning and a scientific meaning. In common English, 'theory' has the same meaning as hypothesis, synonymous with the scientific meaning of model, whereas the scientific use of the word 'theory' has the common English meaning of fact, synonymous with law. No foot function hypothesis has reached a scientific status above Kuhn's definition of paradigm.[1]**

Gravity, evolution and plate tectonics have all been scientific hypotheses that have grown in status to paradigm and with increasing evidence became true scientific theories or laws. They will ever remain so unless some surprising information appears, like supernatural sticky tape to disprove gravity.

The pivotal aims of each foot function hypothesis has been to present a normal, a foot type classification and finally describe compensations occurring where normalcy does not occur, resulting in pathology. Such issues, in regards to 'foot function models', have been extensively discussed by Lee,[2] and all podiatrists would do well to read his seminal work on the subject.

Although it has been claimed that the field of podiatric biomechanics was born in the California College of Podiatric Medicine in the 1960s,[3] foot dysfunction was largely espoused by established authorities of orthopaedic medicine and modified by numerous podiatric clinicians and teachers during the 1920s and 1950s.[2] Merton Root graduated in 1952 into a conglomeration of theories and treatments, unsupported by scientific fact, and fundamentally based around foot-balance concepts.[2]

Root's foot classification and his declaration of the subtalar neutral position was inspired by Carl Linnaeus botany classification, and used the research on the lower limb available at the time, particularly the work of Inman on joint motion interdependence of the lower limb and Manter's work on the subtalar joint axis.[2] Root's ideas on subtalar joint axis motions were later refined by the work of Green & Carol.[4] However, by the early 1990s, papers were already questioning the validity of Root's concepts.[5, 6]

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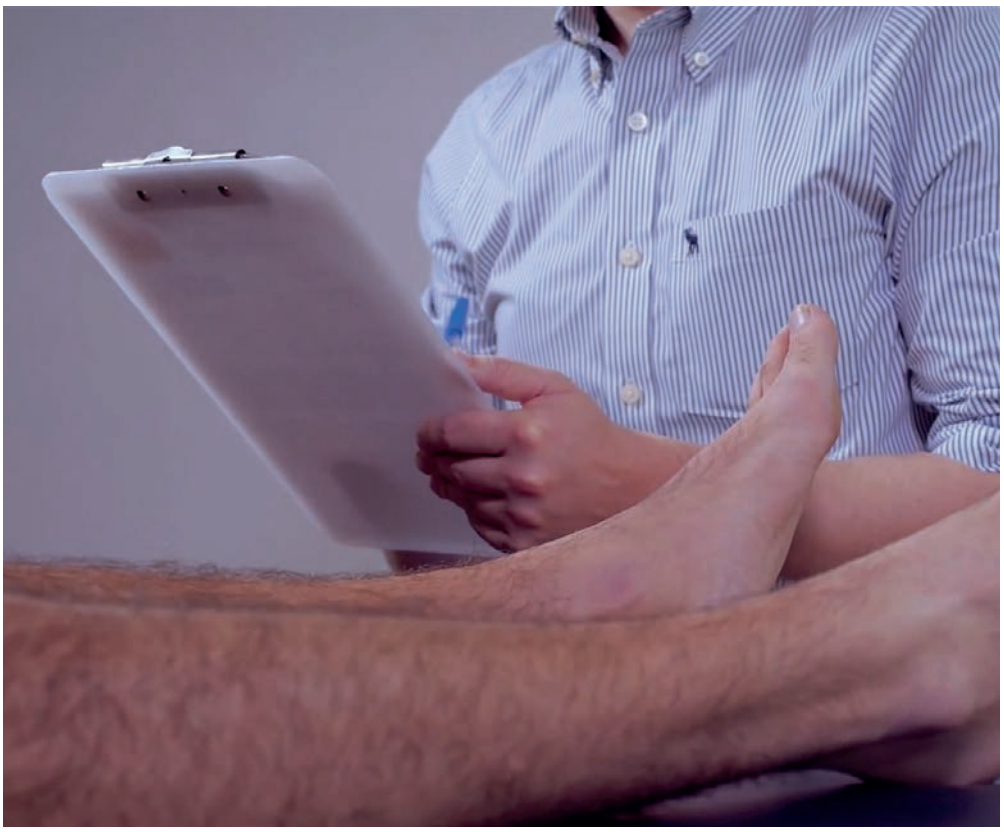
New models to explain foot pathology appeared including Dananberg's 'Sagittal Plane Facilitation' model,[7, 9] which was greatly influenced by the work of Hick's 'Windlass model'[10] and work on the calcaneo-cuboid function and high and low gear propulsion.[11] Kirby's 'Rotational Equilibrium' model focused on moments around a proposed subtalar joint axis lying in the transverse plane, influencing frontal plane motions of the foot.[12, 13] Despite these models not being well supported by scientific papers, both have become highly popular, and have been accommodated into the 'Centre of Pressure model' proposed by Fuller[14, 15] and the 'Unification Theory' proposed by Harradine et al.[16]

Other models such as the 'Inverted pendulum' model,[17] 'Tissue Stress' model,[6] and 'Impact Forces and Muscle Tuning',[18] despite being better scientifically evidenced, have remained largely ignored in podiatry. Models also



> *NO PROPOSED MODEL ON FOOT FUNCTION HAS YET REACHED A STAGE OF SCIENTIFIC 'THEORY', THEREFORE WE HAVE NO SCIENTIFIC 'THEORY' THAT EXPLAINS FOOT PATHOLOGY.*

exist including looking at metatarsal parabola,[19, 20] shoe wear patterns,[21] and to complete the circle foot strength,[22] taking us back to the original concepts of the weak feet models of Durlacher & Thomas from the 19th Century.

No proposed model on foot function has yet reached a stage of scientific 'theory', therefore we have no scientific 'theory' that explains foot pathology. Yet we have an enormous amount of data on the behaviour of tissues under load and increasing data on the variability of morphology and gait.[23] Fundamentally, treatment has not changed from the beginnings of orthopaedic foot therapies, which remain essentially shoe selection, muscle and functional rehabilitation, and support to allow healing or to adapt for functional loss.

With the huge amount of data on lower limb biomechanics now available to us, the correct 'theory' may be already staring us all in the face. At the moment a favourable hypothesis might be of injury occurring when tissue stress tolerances are exceeded, and the mechanism for this must be sought for within the individual's normal rather than a population normal. ■

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# FOOT PAIN

## WHAT ARE THE BIG ISSUES?

MSK SPECIAL

### Epidemiology of foot pain: the big picture

Epidemiology is the study of the patterns, causes and impacts of disease. In contrast to clinical practice, where diagnosis and treatment decisions are made on individuals, epidemiology relates to the evaluation of large groups of people. As a relatively young and small profession with limited research infrastructure, podiatry has had little opportunity to explore the 'bigger picture' of foot disorders. However, this is now changing.

One of the most promising developments in recent years has been the establishment of large, population-based epidemiology studies which incorporate detailed information on foot disorders. Such studies include the Framingham Foot Study of 3,378 people in Framingham, Massachusetts, USA,[1] the Clinical Assessment Study of the Foot of 5,109 people in North Staffordshire, UK,[2] and the North West Adelaide Health Study of 4,060 people in South Australia,[3] among others.

Information obtained from such studies is essential for determining the true public health impact of foot disorders for both researchers and policy-makers. Although epidemiology studies may not appear to provide information of immediate benefit to clinicians, they do provide important insights into possible underlying mechanisms responsible for the development of foot disorders, which may lead to significant changes in how certain conditions are managed. As these cohorts are followed over time, we will also be able more fully to understand the natural history of foot disorders, examine why some problems resolve and others persist, and determine which conditions have the greatest economic impact in terms of health care utilisation and lost productivity. This information will be essential for future planning of the health care system, particularly in the context of population ageing.

So what have these studies shown so far? Put simply, foot pain is common and consequential, particularly in older people. At least one in five people aged 45 years and over suffers from foot pain, with at least two-thirds reporting associated disability in activities of daily living.[4] To put this in an even broader context, the population attributable risk for disability in activities of daily living associated with foot problems in older people has been shown to be greater than cognitive impairment, heart problems, vision problems and respiratory disorders.[5] Foot disorders are also now well established as an independent risk factor for accidental falls,[6] the leading cause of injury-related death in older people. Taken together, these findings

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> *FOOT DISORDERS ARE ALSO NOW WELL ESTABLISHED AS AN INDEPENDENT RISK FACTOR FOR ACCIDENTAL FALLS, THE LEADING CAUSE OF INJURY-RELATED DEATH IN OLDER PEOPLE.*

confirm that foot disorders are common and have an impact far beyond localised pain and discomfort, and are therefore a legitimate public health problem worthy of investigation.

## The obesity epidemic and foot pain

The development of foot pain is multi-factorial, with increased age, female sex, inappropriate footwear and several chronic diseases being recognised as risk factors. However, as our waistlines continue to expand, greater attention is being paid to the role of obesity in foot pain. Increased body mass index has consistently been shown to be associated with foot symptoms. The most obvious explanation for this is mechanical – that is, the bones and soft tissues in the feet simply become overstressed by the additional load they are required to carry. There is support for this in the scientific literature, with a recent systematic review concluding that overweight or obese individuals have flatter feet and generate much higher loads under their feet when walking.[7]

A less obvious explanation is metabolic. Fat is now well-recognised as more than just an energy store – it also secretes several substances (adipokines) that, amongst many other roles, may contribute to inflammation and pain sensitisation. The proposed link between the metabolic role of fat and musculoskeletal pain initially arose from the osteoarthritis literature. Increased weight was found to be strongly associated with knee osteoarthritis, which was originally attributed to mechanical loading. However, a similar link with hand osteoarthritis suggested that the mechanical explanation was insufficient – after all, obese people don't walk on their hands.[8] This discovery led to a re-evaluation of the obesity-osteoarthritis link, with the focus shifting to metabolic factors.

The metabolic consequences of excess fat also appear to play a role in foot pain. In a recent cross-sectional study, fat mass, specifically android fat mass (fat around the stomach) was associated with foot pain, but skeletal muscle mass was not.[9] Subsequent studies have confirmed these findings, and taken together they strongly suggest that foot pain can be added to the growing list of co-morbidities related to obesity, and that both mechanical and metabolic factors are responsible. Given the current trajectory of the obesity epidemic, effective podiatric management of foot pain in the future may require greater consideration of the influence of bodyweight and the role of lifestyle factors such as diet and exercise.

## Foot osteoarthritis: common and disabling, but under-researched

Osteoarthritis is the most common musculoskeletal disorder in the world and is responsible for substantial disability.[10] Foot involvement, however, has been largely neglected in the research literature until relatively recently. The first radiographic atlas focusing on foot osteoarthritis was published by our group in 2007,[11] some 50 years after the original osteoarthritis atlas by Kellgren & Lawrence. Furthermore, in contrast to the extensive randomised trial literature pertaining to osteoarthritis of the knee, a Cochrane review on foot osteoarthritis published in 2010 found only one small, low-quality trial of physical therapy.[12]

Fortunately, research into foot osteoarthritis is finally gaining momentum, both from an epidemiological and clinical trial perspective. By applying the La Trobe atlas to a primary care population (the Clinical Assessment Study of the Foot), the prevalence of symptomatic radiographic foot osteoarthritis (i.e. both radiographic changes and symptoms) in people aged over 50 years has recently been estimated as 16.7% – a prevalence similar to the knee, and higher than the hip.[13] Two phenotypes of foot osteoarthritis have also been identified: osteoarthritis isolated to the first metatarsophalangeal joint, and a polyarticular form incorporating multiple joints of the midfoot.[14]

The recognition of foot osteoarthritis as an important but under-researched condition is also evidenced by the funding of clinical trials by nationally-competitive research funding bodies such as Arthritis Research UK and the National Health and Medical Research Council of Australia. Although there is still considerable work to be done, there appears to be significant potential for mechanical interventions such as foot orthoses and footwear to reduce pain and improve function in people with osteoarthritis of the midfoot[15] and first metatarsophalangeal joint.[16]

## Summary

From a public health perspective, the 'big issues' related to musculoskeletal foot pain are population ageing, the epidemic of obesity, and the increasing prevalence of osteoarthritis. The combination of these factors will ensure that foot pain will remain a common and disabling condition with a significant economic impact. ■

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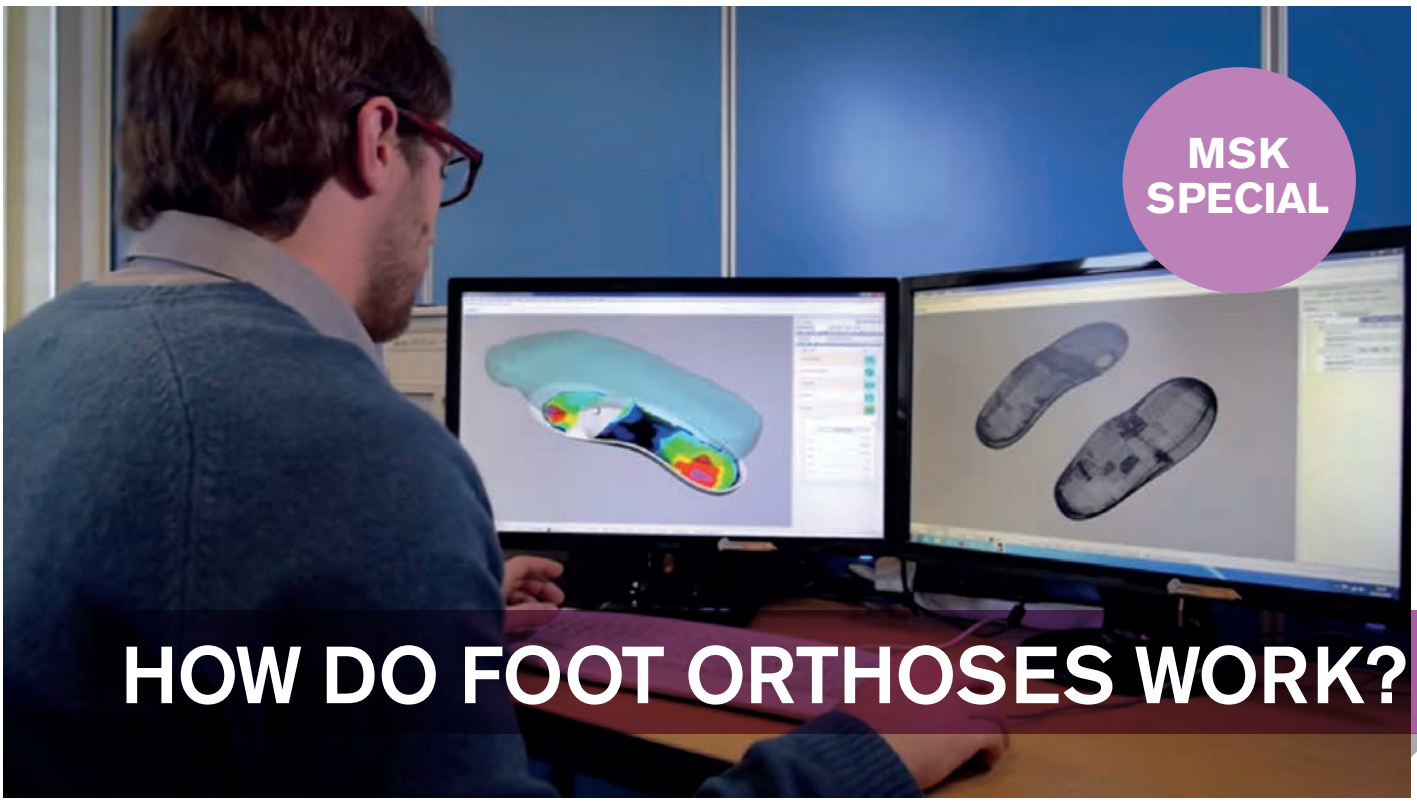

MSK SPECIAL

# HOW DO FOOT ORTHOSES WORK?

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## Introduction

Foot orthoses (FOs) are a common intervention for foot and lower limb problems.[1] Randomised trials have found that contoured prefabricated or customised FOs are effective for some conditions,[2,3] and can prevent several overuse injuries.[3,4] However, even though FOs are beneficial, investigating how they work is complex and has provided substantial challenges for researchers.[5] This is due, in part, to there being many types of FOs, variation in orthotic prescription, inconsistent terminology, and no widely adopted international classifications and guidelines.[4] Furthermore, there are a number of methods that can be used objectively to evaluate the effects of FOs, with no one method recognised as being the primary method. In an ideal world, however, we would know exactly which conditions FOs are effective for, as well as knowing how they work (i.e. their effects).

There are numerous theories and hypotheses about how FOs work, however the most appropriate way in which to investigate their effects is through rigorous and, at times, pain-staking research using valid methods. Over the past few decades there have been an increasing number of studies that have investigated how FOs work. While these studies provide some objective evidence, the evidence relates more to their physical effects on the body, whereas there has been little research linking these physical effects to how, for example, they decrease pain. That is, we can measure the physical effects of FOs, but the actual link between these effects and symptom reduction (i.e. exactly how they work) has received limited investigation. With this in mind, most investigations that have studied the effects of FOs have been laboratory-based biomechanical studies and it is these studies that this article is based on. More theoretical ideas about how FOs work is not covered in this article.

## Methods to assess the effects of FOs

The majority of studies that have assessed the biomechanical effects of FOs have generally utilised one of four assessment techniques: (i) motion, (ii) plantar pressure, (iii) postural sway and/or (iv) muscle activity.

### (i) Motion assessment

Assessment of the effect of FOs on the body's motion (i.e. kinematics) is generally done by using 2- or 3-D motion analysis. Assessment can be done statically or dynamically, although nowadays gold-standard assessment is considered to be dynamic 3-D assessment. There are different systems but researchers have generally gravitated towards visual marker-based systems, such as VICON, where multiple cameras detect retroreflective markers placed on specific parts of the foot, leg and body. Such systems are complex and have some limitations (e.g. different models for marker placement and difficulties visualising markers with footwear), but they do provide a reasonable picture of how a FO changes foot or leg motion.

Kinematic studies have consistently demonstrated that FOs produce relatively small changes in position or motion, particularly to joints proximal to the foot.[6-8] Medially posted (i.e. anti-pronatory) FOs tend to decrease rearfoot pronation in the order of a few degrees, but most studies generally find smaller changes higher up the leg.[7,9] A recent study found a linear close-response relationship with rearfoot posting and change in several kinematic variables (e.g. increasing rearfoot varus posting leads to decreasing rearfoot eversion).[10] Furthermore, more aggressively posted inverted FOs have been found to have greater effect higher up the leg than standard Root style FOs.[11] However, other studies have found that the effects of posting and moulding of the shell of the FO are different, with the effects of moulding being dominant.[12,13] Essentially though, to obtain maximum effect on motion of the foot (e.g. limiting rearfoot eversion), if that is the desired purpose of intervening with FOs, moulding and posting are required.[13]

As stated before, change in foot and leg motion as a result of FOs is generally very subtle.[14] This may be a reflection of kinematic assessment techniques, whereby measurement is usually focused around a small number of joints (e.g. the rearfoot complex), whereas larger effects may be detected if a larger number of joints were assessed (e.g. all joints that a specific muscle, such as tibialis posterior, spans). These wider changes in motion across multiple joints may lead to larger overall effects that collectively lead to symptom relief.

**Above image:** Permission granted by Dr Jill Halstead, Section of Clinical Biomechanics and Physical Medicine, University of Leeds.

Related to this issue is that researchers are still grappling with what size of kinematic change is clinically important when related to worthwhile symptom change for the patient. This is a fundamental issue for any biomechanics research – what amount of biomechanical change (i.e. in the gait laboratory) is clinically worthwhile for the patient with symptoms or functional impairment? For example, a study may find a statistically significant finding (e.g. change in rearfoot eversion), but it is not clear if that equates to a change that will reduce symptoms, for example in a patient with tibialis posterior muscle/tendon pathology. Another key issue for the evaluation of FOs is that it has been observed that there is large kinematic variation in how individuals respond, which highlights the complexity of explaining the mechanism of action of FOs.[15,16]

In summary, FOs have been found to affect rearfoot kinematics with less effect higher up the leg. The kinematic effects of FOs are generally small at the relatively limited number of joints that have been assessed and can be quite variable in different individuals. Finally, the relationship between the kinematic effects of FOs and symptom reduction has been poorly studied and is not clear.

### (ii) Plantar pressure assessment

Plantar pressure assessment (i.e. kinetics) is achieved by using either fixed platform or in-shoe insole systems, although there are also walkway and treadmill systems available now. It is accepted that in-shoe insole systems (e.g. the pedar or F-scan systems) are the most appropriate way to assess plantar pressure changes with FOs. However, these systems are limited by certain issues. For example, plantar pressure insoles have fewer pressure sensors per square centimeter compared to platform systems, so spatial resolution is an issue, which may affect how accurately the insole measures plantar pressure with and without a FO, or when different FOs are compared.

Nevertheless, in contrast to kinematic assessment, findings from plantar pressure studies convincingly and systematically demonstrate that FOs – particularly ones contoured to the arch and heel – alter both the amount and timing of force and pressure underneath the foot. Specific changes of contoured FOs include a reduction in plantar pressure under the heel and forefoot by redistribution into the arch of the foot (achieved via increasing the surface area that the ground reactive force is distributed over by way of the contour of the device).[17-20] One study has shown no difference between prefabricated and customised contoured FOs in this pressure redistribution.[21]

In addition to the effect of the contour of a FO is the effect of posting and other methods to decrease pronation of the foot. One study that evaluated increasing varus rearfoot posting found a dose-response effect on plantar pressures.[22] Another study that evaluated the medial heel skive found that 4mm and 6mm skives significantly increased pressure in the medial heel in pronated feet.[23] Finally, forefoot padding (e.g. plantar metatarsal padding) can also decrease plantar pressure in the forefoot by specifically redistributing pressure away from the metatarsal heads.[24]

In summary, contoured FOs redistribute plantar pressure from the heel and forefoot to the midfoot. In addition, forefoot padding can redistribute plantar pressure away from painful metatarsal heads. Assessment of plantar pressures provides the most convincing evidence for the effects of FOs by way of the size of the effect, which is substantially larger than kinematic effects, and because the changes are more systematic across patients.

### (iii) Postural sway assessment

Assessment of postural sway is a proxy measure of balance, which is important for people with poor balance and who are at risk of falling. Assessment of postural sway can be achieved using plantar pressure equipment, so could be considered under plantar pressure, but because it is not directly concerned with measurement of pressure under the foot, it will be dealt with under its own heading. Measurement of postural sway is still relatively new and there has not been much research in this area, even though it has significance for reducing the burden of falls. In addition, the research in this area so far is generally poorly controlled, so the findings may be inaccurate because of confounding (i.e. due to extraneous unwanted effects). A further limitation of this method of assessment is that many of the systems (e.g. the NeuroCom) test patients statically via postural sway while standing, and studies tend to assess immediate effects of FOs only. Clearly, this limits the generalisability of this assessment as it may not relate to postural control in the dynamic setting (e.g. when a patient is walking, running, or negotiating obstacles) and questions remain about the long-term impact of adaption to FOs, which may lessen the effect over time. More recently, techniques that assess centre-of-pressure using plantar pressure walkways (e.g. GAITRite) or platforms (e.g. emed or MatScan) have been used, which can incorporate more dynamic tasks.

Systematic reviews have shown an improvement in balance with certain types of insole, for example vibratory insoles, but textured insoles appear to not be beneficial for balance in older adults[25,26] However, the studies in the reviews were generally of very low quality, so their conclusions are limited. One of the systematic reviews also concluded that there is a positive effect of contoured FOs on balance control in older participants.[25] However, a recent well-controlled study found no effect of insoles or contoured prefabricated FOs on balance in healthy adults.[27] The effects of FOs on balance and sway in people with neurological conditions, such as multiple sclerosis[28] and Parkinson's disease,[29] has also been studied. Although initial findings are

promising in these populations, larger randomised trials with longer follow-up are required.

In summary, this area of research is still relatively new and improvements in research design to avoid confounding and bias are needed. It is difficult, therefore, making conclusions about whether FOs or insoles have an effect on postural sway, particularly a lasting effect on balance that leads to a reduction in falls in older adults and people with neurological conditions.

### (iv) Muscle activity assessment

The activity of muscles is most frequently assessed by electromyography (EMG). EMG assessment is achieved by detecting electrical activity of muscles through either surface or in-dwelling (i.e. in the muscle belly) electrodes. EMG assessment, particularly if using in-dwelling electrodes to access deep muscles, is highly complex. In addition, the data are difficult to analyse, there is often great variability in participants' EMG response to FOs, and the meaning of the aggregated data from studies is not straight forward.

Nevertheless, the effect of FOs on EMG activity in the lower limb has demonstrated statistically significant changes in many lower-limb muscles (e.g. tibialis anterior and peroneus longus), although the clinical meaning of these data is still uncertain.[30] Again, like kinematic data, the amount of change required with a FO to lead to a clinically worthwhile change for a patient is not known. So, although statistically significant findings may be found (e.g. less tibialis posterior activity and more peroneal activity with anti-pronatory FOs), it is still not understood what amount of change will reduce symptoms in a symptomatic patient.

Notwithstanding this limitation, a systematic review found that FOs increase activation of tibialis anterior and peroneus longus, and may alter low-back muscle activity.[30] Most of the studies in the systematic review used surface EMG, which is generally easier to use and is non-invasive, but does not allow investigation of deeper muscles, such as tibialis posterior. In a more recent study using in-dwelling EMG for deeper muscles, certain contoured anti-pronatory FOs were found to significantly alter tibialis posterior and peroneus longus EMG amplitude in people with flat-arched feet, and a prefabricated FO with rearfoot varus posting altered peroneus longus activity towards that demonstrated in normal-arched feet.[31] Investigating rearfoot posting more closely, a recent study found no effect of increasing varus rearfoot posting on EMG activity,[22] although more extreme rearfoot posting (i.e. inverted style FOs) has been found to effect peroneal activity.[32]

In summary, FOs do alter EMG activity of certain muscles in the lower limb (e.g. tibialis anterior, tibialis posterior and the peroneals), but the meaning of this is still unclear, as is whether the size of the effect is clinically important.

### (v) Other assessment techniques

Other measures have been used to investigate the effects of FOs, such as oxygen consumption (i.e. physiological efficiency) and radiographic/medical imaging assessment. However, only a few studies have used these techniques, and some are poorly controlled, so the evidence is limited. Moreover, measures such as oxygen consumption are ultimately a composite representation of some of the other effects outlined above (e.g. EMG changes may lead to a more efficient gait, which in turn may lead to decreased oxygen consumption), and radiographic assessment (except fluoroscopy) is limited to static assessment and has obvious ethical considerations relating to ionising radiation, although new medical imaging techniques are beginning to address these limitations. Nevertheless, combining physiological measures, such as oxygen consumption, with biomechanical measures in future studies may help link the biomechanical effects of FOs to physiological efficiency and possibly symptom reduction or functional improvement. Medical imaging will also offer insight into whether longer-term use of FOs cause beneficial change to damaged tissues in symptomatic conditions, such as plantar heel pain.

## Conclusions

While there is no consensus on how FOs work, there is evidence to suggest small, yet significant, changes to the function of the lower limb with a variety of orthotic devices. Studies have shown effects on kinematics and EMG activity in the foot and leg. In addition, FOs may also affect postural sway and balance. However, plantar pressure changes appear to provide the most convincing explanation of the effects of FOs as the changes observed are larger and more systematic. Further research investigating how FOs work is necessary, which should include more robust study designs and larger sample sizes, as well as linking the biomechanical effects of FOs with more physiological and/or structural changes of tissues.

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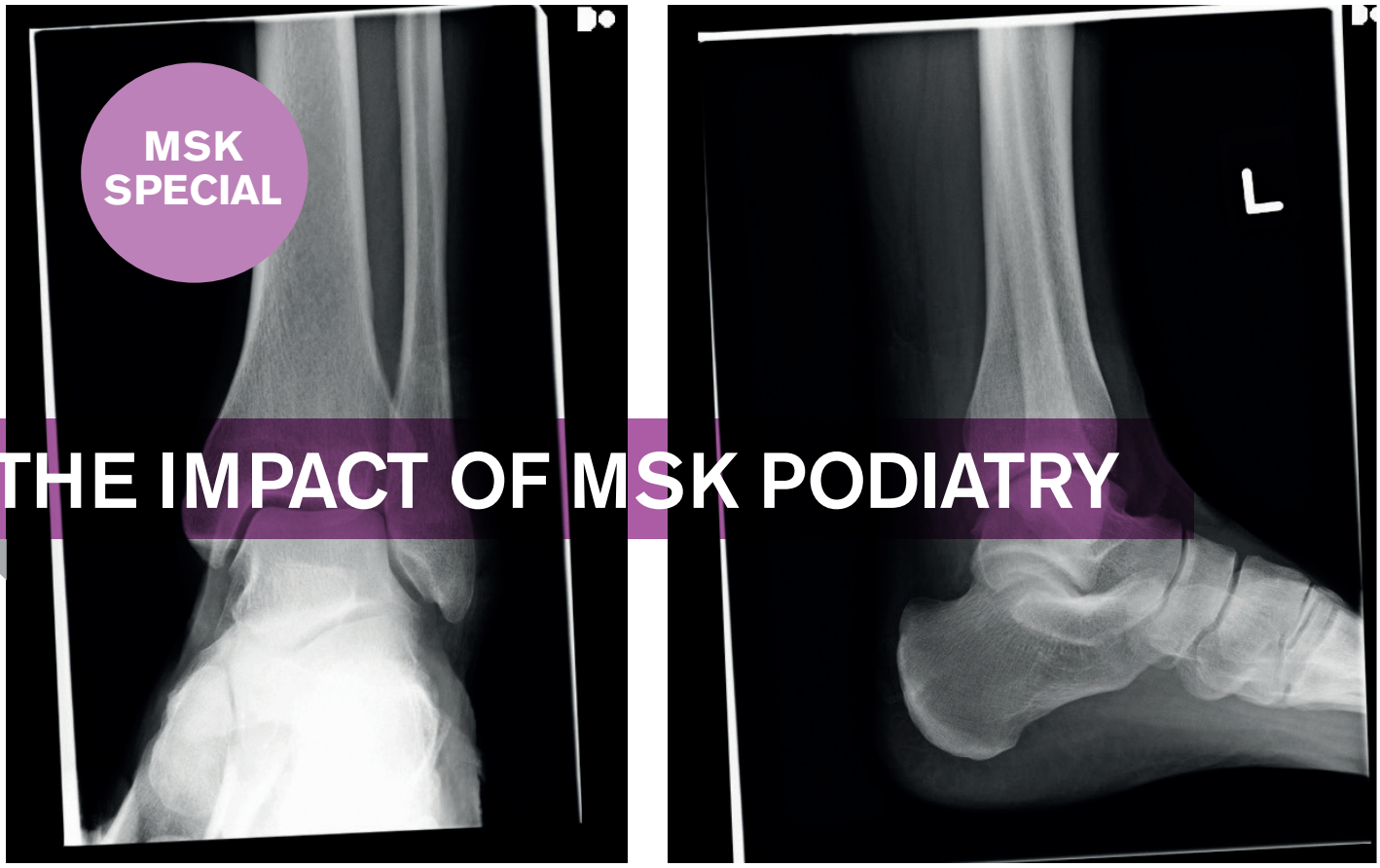


# THE IMPACT OF MSK PODIATRY

**The emergence of musculoskeletal (MSK) podiatry as a discipline within podiatry is a relatively late development, and therefore work that robustly evaluates the impact of this is yet to be fully addressed. In the core podiatry project,[1] commissioned by the College of Podiatry, a systematic review of guidelines and recommendations for podiatry and foot health management (2000-2015; n=229) indicates that 49% of evidence is related to management of foot health in diabetes. There is thus very little evidence on which to base an assessment of impact of MSK podiatry.**

From this we could argue that we should look at emergent evidence and the trends in podiatric clinical practice for evidence of impact of MSK podiatry over the past 10 years. The Runting Research Project, awarded to Dr Lisa Farndon in 2015, investigated 'the current patient population managed by UK podiatrists (NHS and Independent) and the evidence available to support the effectiveness of podiatric contributions to health and well-being'. It emerged that the main foot conditions presenting to podiatry were corns/callus, nail pathologies, foot ulcers and MSK problems and the main areas where podiatrists are currently contributing are in diabetes, rheumatoid arthritis, orthopaedics (with MSK and surgery treatments) and nail surgery.[1]

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But what is impact? According to the Oxford English Dictionary, impact in this context is defined as 'a marked effect or influence'. If we break this down into the components of what constitutes MSK podiatry, it is possible that the burgeoning number of new foot orthotic devices on the market are an example of MSK podiatry impact. Conversely, the fact that there is no consensus of preference for one foot orthotic device over another may indicate that no one device format is particularly effective and therefore not impactful.[2]

Indeed, whilst systematic reviews do recommend that foot orthoses have some effect,[3,4] and that prefabricated devices are as effective as bespoke devices,[5] this does not give an indication of impact. Effectiveness is the degree to which the devices are successful in producing a desired result not how impactful those prefabricated devices are. If we go further, management of MSK conditions includes a spectrum of techniques, not just the use of foot orthoses, but the longer term impact of the use of these is yet to be evaluated.

There is some incandescence in this discussion. The Research Excellence Framework (REF) 2014 was the first exercise to assess the impact of research outside of academia. Impact here was defined as 'an effect on change or benefit to the economy, society, culture, public policy or services, health, the environment or quality of life, beyond academia'. The REF 2014 impact case study database includes 6,679 impact case studies. Podiatry-related submissions can mostly be found in Unit of Assessment 3 'Allied Health Professions, Dentistry, Nursing and Pharmacy'.

From that REF census, three key podiatry centres provided Impact case studies, all of which interestingly related to MSK podiatry: University of Salford, Glasgow Caledonian University and University of Leeds. Each of these Centre's impact case studies is available to download (http://impact.ref.ac.uk/CaseStudies/).

Within these documents, researchers provide evidence of the impact of their research for the previous five years. Research by the Salford team has accelerated innovation of footwear and foot orthotic products to increase mobility, independence and quality for life for a wide range of users. Glasgow Caledonian University researchers have dramatically changed the manufacture of custom ankle-foot and foot orthoses through additive manufacturing (3D

printing) combined with improved design personalisation. The University of Leeds has driven improvements in MSK foot care services through its 'FASTER' (Foot and Ankle STudiEs in Rheumatology) clinical trials and a national survey that directly informed NICE guidelines on foot care in arthritis.[6]

Whilst it is disappointing that only three centres provided impact statements, an estimated 20-30 podiatrists were returned as individuals in that REF census and there are others that we are aware of anecdotally that were embedded in a wider Allied Health Professions and nurse submission agenda. In my own Institution, University of Southampton, our research has contributed towards the further understanding of foot manifestations in MSK conditions.[7, 8]

The work on the use of diagnostic ultrasound imaging by podiatrists to detect foot manifestations of inflammatory arthritis has impacted on changing clinical practice as it introduced the concept of MSK imaging of the foot and ankle by podiatrists such that the technique is now being embraced within routine MSK podiatry clinical practice across the UK.[9]

From this evidence platform, the immediate impact, as well as patient benefit, has been growth in design and development of new technologies in the field of podiatry MSK practice. New technologies, such as diagnostic ultrasound, are changing the way podiatrists are able to diagnose MSK pathology within the foot and ankle allowing for more timely and targeted therapies.[10] Other technological advancements such as foot-interface pressure measurement and 3D kinematic analysis have enabled informed design of orthoses.[11] The next phase in this latter development involves newer techniques in manufacture of foot orthoses such as foot scanning and 3D (or even 4D) printing.[12]

The impact of the work to understand epidemiology and pathological features of MSK conditions affecting the foot and ankle has provided clinicians with better insights in the targeted management.[10] The impact of this information has also been towards researcher development of better informed screening tools that have been systematically validated and tested against traditional clinician-led assessments. These tools are available for use both within the foot-care clinical environment and in the research laboratories.[13, 14]

As healthcare becomes increasingly global, new classification systems for assessment of foot and ankle MSK status will also emerge. These systems will facilitate standardised data collection for both research and clinical purposes, with validated variations that span the whole range of diversity in populations and multicultural aspects. The impact of this information will be tremendous, however strict attention will need to be paid to governance procedures in sharing and use of such data.

In summary, MSK podiatry is an emergent field in which impact has yet to be determined. With continued evolvement of clinical practice and melding of assessment of the effectiveness of the MSK interventions, evidence for impact will follow. We need to ensure that we continue to gather evidence of the impact of our interventions as well as effectiveness and to increase the visibility of what and how clinicians working in the field of MSK podiatry achieve in terms of impact. ■

*MSK PODIATRY IS AN EMERGENT FIELD IN WHICH IMPACT HAS YET TO BE DETERMINED. WITH CONTINUED EVOLVEMENT OF CLINICAL PRACTICE AND MELDING OF ASSESSMENT OF THE EFFECTIVENESS OF THE MSK INTERVENTIONS, EVIDENCE FOR IMPACT WILL FOLLOW.*

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MSK SPECIAL

# WHAT HAS RESEARCH TAUGHT US IN THE LAST 10 YEARS?

**This is a great opportunity to take a look at some of the MSK injuries where we thought the knowledge was cast in stone… absolutely confident in the stories we told and the treatments we offered, only to have our fleeting confidence shattered by that most savage of beasts… research.**

To that end, I shall discuss two injuries where I believe the treatment has been fundamentally changed by research in the past 10 years. For one of these certainly the treatment has reverted back to the original thought processes, at least partially.

First up is Achilles tendonitis. I picked this first because it has had an influence on the other condition I shall discuss, and because the way we view this condition has changed in more ways than one.

First, we no longer call it Achilles tendonitis, primarily because eminent sports physician and researcher Karim Khan[1] pleaded with readers of the BMJ to *'accept the irrefutable evidence that the term tendinitis must be abandoned to highlight a new perspective on tendon disorders'.*

At the time of this editorial it was necessary to send out a strong message that chronic tendinopathy had a different aetiology from inflammatory conditions such as rheumatoid arthritis (RA), and to emphasise that traditional strategies such as corticosteroid injection and NSAIDs do not adequately address the pathology.

However, despite the fact this editorial appeared a little more than 10 years ago, the term tendonitis has largely been consigned to the dustbin of medical nomenclature… until recently.

During the first 10 years of the 21st Century, the tendinopathy model dominated the discussion of the injured tendon. This was based on a number of important papers.

First there are models that attempt to explain why tendons fail. The cumulative damage and vascular insufficiency models fall into the first group.[2] Second, a group of models attempts to explain why tendons fail to repair themselves and includes the 'failed healing response'[3] and the continuum theories of tendinopathy.[4] This last paper by Jill Cook and Craig Purdham is rightly considered one of the seminal sports medicine papers of all time and has been hugely influential along with the degenerative paradigm.

**SIMON J BARTOLD**
**FELLOW FACULTY OF PODIATRIC MEDICINE, THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS (GLASG), BSC,FASMF, FAAPSM SPECIALIST SPORTS PODIATRIST**

Furthermore, the degeneration without inflammation paradigm largely defined our treatment options, many of which were completely new to MSK medicine. These included:

1. Physical exercises including eccentric exercises (EE) pioneered by Swedish Orthopaedic surgeon Haken Alfredsen,[5] or other progressive loading regimes.
2. Treatments using blood and blood products that aim to improve tendon healing and remodelling.
3. Treatments that aim to reduce the pain associated with tendinopathy rather than healing the tendon itself (such as sclerosant or high-volume injections).
4. Extracorporeal shock wave therapy (ESWT).

It is important to note that Achilles tendinopathy is not a consistent condition; it may occur at any level along the tendon or myotendinous junction, and certainly we have at least two clearly distinguished conditions occurring at the insertion and midsubstance that respond differently to different treatments.[6] Unfortunately, despite the focus on healing of the 'degenerative tendon' in the last 10 years, none of the treatment protocols reliably heal the failing tendon.

We could explore this topic at greater length because there is much to discuss, but I have been allocated 1000 words for this article and I am already halfway there. The fact is, denying the existence of inflammatory processes in Achilles tendon injury is akin suggesting dinosaurs roamed the earth during the time of man.

There have been major advances in immunohistochemistry and gene expression analysis; research is not stagnant, it changes according to the available technology. Several studies, in both humans and in animal models, have shown an inflammatory reaction both in established tendinopathy and in the early overload response. In particular, Schubert and coworkers,[7] have demonstrated the presence of macrophages and T- and B-lymphocytes in chronic Achilles tendinopathy. The authors also studied asymptomatic spontaneously ruptured

tendons and in contrast found large numbers of granulocytes (to be expected in the case of an acute traumatic event) but did not see significant numbers of macrophages, T- or B-lymphocytes.

Most studies of tendon pathology have histologically demonstrated an increase in tenocytes and that the tenocytes are larger than normal.[8] Tenocytes are well known to proliferate and become more metabolically active in response to cytokines and growth factors that are part of the inflammatory response (e.g. platelet-derived growth factor (PDGF), IGF-1 and TGF-ß). Thus, tenocyte hyperplasia and hypertrophy may provide indirect evidence of up-regulated inflammatory mediators.

So, the tide has turned and Madame Research is reconsidering her position on the role of inflammation in tendinopathy. The bottom line is that this is still the correct term to use, and inflammation, according to research, should still not be considered the primary driver of pain in chronic tendon injury. However, this gives us important cues for treatment, which should remain primarily mechanical, and have a large focus on the pain component (which we do not have time to discuss). However, is now seems clear that, despite the consensus that mechanical overload is the predominant feature in the development of Achilles tendinopathy, inflammatory processes have a clear role to play in the progression of disease.

If you are interested in this topic in more detail, take a look at Jonathon Rees' outstanding overview.[2]

The second condition I would like to cover bears more than a passing similarity to our Achilles tendon discussion. There is a question mark over the role of inflammation, which drives the descriptive nomenclature and the treatment protocols. Moreover, it is by far the most common MSK condition presenting to the podiatrist, and about1 in 10 of the population can expect to suffer this condition. The list of treatment options is huge, ranging from infiltration of corticosteroid, to swinging a dead cat around one's head in a cemetery at midnight (also most effective for verrucae!).

We are, of course, talking about the ubiquitous plantar fasciitis, one of the most troublesome and reliably unreliable of all conditions of the foot to treat.

Historically, we have discussed plantar fasciitis as a condition where the plantar aponeurosis becomes inflamed at its insertion into the calcaneus as a result of overload on the medial longitudinal arch, secondary to microtearing. If one is to search the term on the internet, a variety of truly horrific and terrifying images will appear depicting various degrees of carnage at the plantar fascial insertion. The plantar fascia of course has three main 'slips': medial, lateral and central, with the medial slip most commonly implicated in the condition of plantar fasciitis. This is curious given the medial slip is thin and virtually non-existent at its proximal level.[9] Similarly, the structure of the lateral band appears variable in nature,[10] ranging from relatively thick and fully developed, to complete absence in approximately 12% of individuals. So, the research does not back up the perception of the injury, and what we have been told is not borne out in anatomy.

Likewise, and in a very similar manner to Achilles tendinopathy, the research questions the role of inflammation, and thereby the nomenclature and treatment. Recently, there has been a push to abandon the term plantar fasciitis in favour of plantar fasciopathy, a mouthful if ever there was one, or a more simple generic term like 'plantar heel pain'. This seems sensible to me, especially given the multifactorial nature of plantar heel pain. Plantar fasciitis is a diagnosis, and this may well be what we are dealing with, but to my mind, until we have confirmed the diagnosis, we should be cautious what we call it. This was brought into focus by Lamont and co workers,11 who found no evidence of inflammation during biopsy of heel spurs in 50 subjects.

Exactly 10 years ago Wearing and coworkers,[12] stated 'Similar to tendinopathy, plantar fasciitis is characterised by a marked degeneration of collagen in which inflammation is not a predominant feature. While clinical doctrine has implicated biomechanical factors that promote excessive tensile strain within the plantar fascia as paramount to the development of plantar fasciitis, scientific support for this premise is limited.'

Ten years on, research has swung her pendulum, and everything has changed again. Inflammation is back on the table, as is the strain model for plantar fasciitis, but in a compression and shear model rather than tension. All, this compels us to rethink our treatment strategies.

So what HAS research taught us in the last 10 years?

- That research can be a cruel mistress; she does change her mind, but that can be a good thing.
- That research, for the most part is impartial, and so is based on the best available practices of the day.
- That those who jump on a particular bandwagon without considering all available possibilities are on a fool's errand. Polarised opinion is bad science and bad practice.

To remain fluid in our thought processes, to question the wisdom of the day, to read the published literature and apply critical thinking processes to what we see, touch, feel and hear on a daily basis. ■

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# THE WALKING PROJECT

**The nation has gone nuts about walking. Walking for fitness, walking for weight control, walking for mental health, walking to reduce emissions; and the list goes on and on. Whichever way you look at this though, it's great news for the nation and great news for podiatrists.**

Walking is something a large proportion of the population does as part of their activities of daily living, and an increase in these activities is a great way for us to promote the work and impact of podiatrists.

May is National Walking Month and includes Walk to School Week (16-20 May 2016), so there are plenty of things to engage with. We would love to se as many podiatrists as possible rolling up their sleeves and getting involved.

We all know that podiatry needs a boost in the eyes of the public to raise awareness and understanding, so we are taking an active part in National Walking Month and asking members to do likewise by signing a pledge to undertake some kind of promotional activity related to walking during the month of May.

At head office we are going to be doing our bit to support you and publicise this on a national level, and together this is one way we can start to have a positive impact on the public psyche.

## Why would you get involved?

Getting involved in National Walking Month has benefits for everyone, whether you work in the NHS, private practice, are a researcher, academic, or work elsewhere in the podiatry sector.

Raising awareness and understanding of podiatry among the general public, other health professionals, influencers and financers will have a positive impact. It's a great way to engage more with your patients, improve referrals, connect with your local community, influence funding or build professional bridges.

**ALISON HART**
**UNDERGRADUATE EDUCATION OFFICER, THE COLLEGE OF PODIATRY**

## How can you get involved?

Get involved by going to the homepage on the Society website and hitting the pledge button!

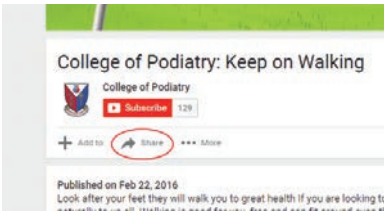
You can pledge to do just one small thing or a whole heap of things, every little helps.

Think about:

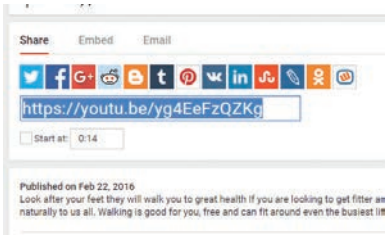
- Upping the ante on social media - share tips and facts about feet and walking through your social media accounts using the Hashtags #TRY20 and #KOW (Keep on Walking)
- Giving out the walking advice postcard to your patients *
- During walk to school week give out children's stickers* in your clinic
- Make contact with a local walking group and offer to go along and give some foot health or footwear advice
- Play the Keep on Walking video in your waiting room*
- Embed the Keep on Walking video into your website **
- Offer to go along to your local primary school during Walk to School Week and give a talk and to the pupils on Foot Health (take along copies of the children's walking leaflet)*

*Postcards, stickers, leaflets, and a download of the Keep on Walking video are all available once you have signed the pledge

**To embed the video in your website, search for the College of Podiatry on YouTube. Once on the CoP page, click the video tab to see the list of videos and select the Keep on Walking Video. When that page loads click Share just below the red subscribe button.




Then click the embed tab and you will be given the code that you need to copy and either embed into your website or pass to your web developer to do this for you.




We have a number of other walking resources on the public website walking page – just visit www.scpod.org/foot-health/keep-on-walking


We would love to see all of your activity, so please take pictures (remember to get patient consent) of all the things you do to promote podiatry and walking during National Walking Month and share with us on social media, on the website or via e-mail. Tell us about everything you take part in throughout the month – the more unusual the better.

So come on, sign the pledge and let us know what you will be doing to promote podiatry and walking in May and let's get podiatry and walking connected in the minds of everyone in the UK. ■


# RESEARCH AND DEVELOPMENT COMMITTEE ACTIVITIES

**The Research and Development (R&D) Committee comprises a group of experts who collectively aim to promote 'the advancement of research and education of the public in the art and science of podiatric health relating in particular, but not limited to, the prevention and the treatment of diseases and conditions of the foot and lower limbs'.**

We act as an advisory committee to the College of Podiatry Academic Board (CoPAB) and have external facing advisory roles with the Council for Allied Health Professions Research (CAHPR) and the European League Against Rheumatism (EULAR). We actively support the Research Student Network chaired by Craig Gwynne and, in 2015, established the College of Podiatry Professoriate. The remit of the College Professoriate is to enable professors with a podiatry background from across the UK to meet on a collective basis to share perspectives and expertise relating to podiatry research and professional development, to support the broad aims and activity of the College.

One of the R&D committee's main activities during the past year has been to produce a strategy for research and development progress over the next five years. This strategy builds on the 2010-2015 Research and Development Strategy of the College of Podiatry and Society of Chiropodists and Podiatrists. The new strategy sets out our vision for the development of research capacity, capability and impact of foot and ankle related research over the next five years. It details how we intend to implement the strategy, the goals and specific objectives we have set out to achieve and how we will measure our success. The strategy is intended to help clinical and research podiatrists as well as other health researchers, professional bodies and partner organisations to further develop and embed foot and ankle related research within practice and share best practice in its wider context. The strategy document will be available for members to comment on and provide feedback to the committee very soon and we welcome any feedback you may have.

As a committee we are actively engaged with the College of Podiatry Conference. Our role within this is to oversee the scientific programme through scoring and governance of the process for acceptance of abstracts onto either oral or poster presentations. Inherent in this process is the awarding of the Jewel in the Crown presentation for the abstract with the highest score. The committee also organises two main sessions comprising a research related masterclass and topical debate. We would welcome any requests for research related topics that the membership would find of particular interest.

**DR CATHERINE BOWEN**
ASSOCIATE PROFESSOR, PATHWAY LEAD FOR MRES
NIHR CLINICAL ACADEMIC PATHWAY, UNIVERSITY OF SOUTHAMPTON

Other success stories have been related to the implementation, overseeing and governance of resources and funding of various projects, awards and fellowships. Two early career researchers, Charlotte Dando and Graham Wylie were awarded bursaries to attend the annual College of Podiatry conference to present their work. This year we launched the first College of Podiatry-Canonbury Fellowship. Mr Sam Glasser of Plymouth University was the 2016 award winner with a prize of £10,000 to support completion of his work 'investigating the impact of diabetic peripheral neuropathy on balance, and the effect of ankle foot orthoses on postural control'. The Runting Research Project (£10,000): 'to determine the current patient population managed by UK podiatrists and the evidence available to support the effectiveness of podiatric contributions to health and well-being' was completed by the Principal Investigator, Dr Lisa Farndon. Watch out for the publication of the full results in Podiatry Now soon. The research project 'Are core podiatry services clinically, and cost effective?' (£119,000) has progressed throughout the year and is expected to provide a valuable resource repository of evidence for members to use when asked about the clinical effectiveness of their practice. The project is a collaboration between the College and a consortium comprising the Universities of Southampton, Oxford and Leeds.

**The current R&D committee members include:**

Dr. Cathy Bowen (Chair);
Prof. Robert Ashford;
Dr. Michael Backhouse;
Dr. Chris Boden;
Dr. Sarah Curran;
Mr. Craig Gwynne (Research Student Network Representative);
Dr. Katie Lagan,
Prof. Caroline McIntosh;
Dr. Stewart Morrison;
Dr. Joanne Paton;
Mr. Mike Patrick (Lay Member);
Prof. Anthony Redmond;
Dr. Anita Williams.

# PRESENTING MY RESEARCH AT THE COLLEGE OF PODIATRY CONFERENCE 2015

**Following submission of my abstract for my research study to the College of Podiatry, I was fortunate enough to receive a Research and Development Bursary in order to present my findings at the 2015 College of Podiatry Conference and Exhibition in Harrogate.**

This provided me with an opportunity to present my current PhD findings for developing a diagnostic tool for the clinical diagnosis of forefoot neuroma in one of the short paper sessions. This 'dipping my toe' into the world of research was a nerve-racking, yet very enjoyable experience.

More importantly, the feedback gained was encouraging and productive from fellow colleagues. It was also a great platform to thank those individuals from the University of Southampton and Solent NHS Trust in supporting me through my clinical academic PhD journey. It was also a privilege to be invited to talk to students at the student careers forum about my unique job role. I hope I have encouraged the curious to explore the world of research as a similar opportunity four years ago encouraged me to pursue this career pathway.

It was great to see such topic variation in the poster presentations which has led me to consider future audit topics for the trust I work in, but also demonstrated the clinical, academic, creative thinking in our profession especially, in blending clinical practice and research to refine or problem solve issues in an evolving profession. Personally, it was exciting to see fellow colleagues disseminate high quality and thought provoking findings that were informing and improving patient experience and outcomes.

The oral presentations provided an insight into the developing specialist roles in vascular, neurology, diabetes and musculoskeletal lower limb health. Speakers in these fields were visible and approachable to offer guidance and mentorship to those wishing to pursue their interest pathway. These presentations also sparked conversation and reflective practice.

For me, the two most memorable plenary presentations were from Professor Dan Bader on tissue viability in clinical care and Mr Tanner on burns and plastic surgery. These highlighted the impressive improvements in healthcare knowledge and technology development to promote high quality patient management of the lower limb, using a multi disciplinary team approach.

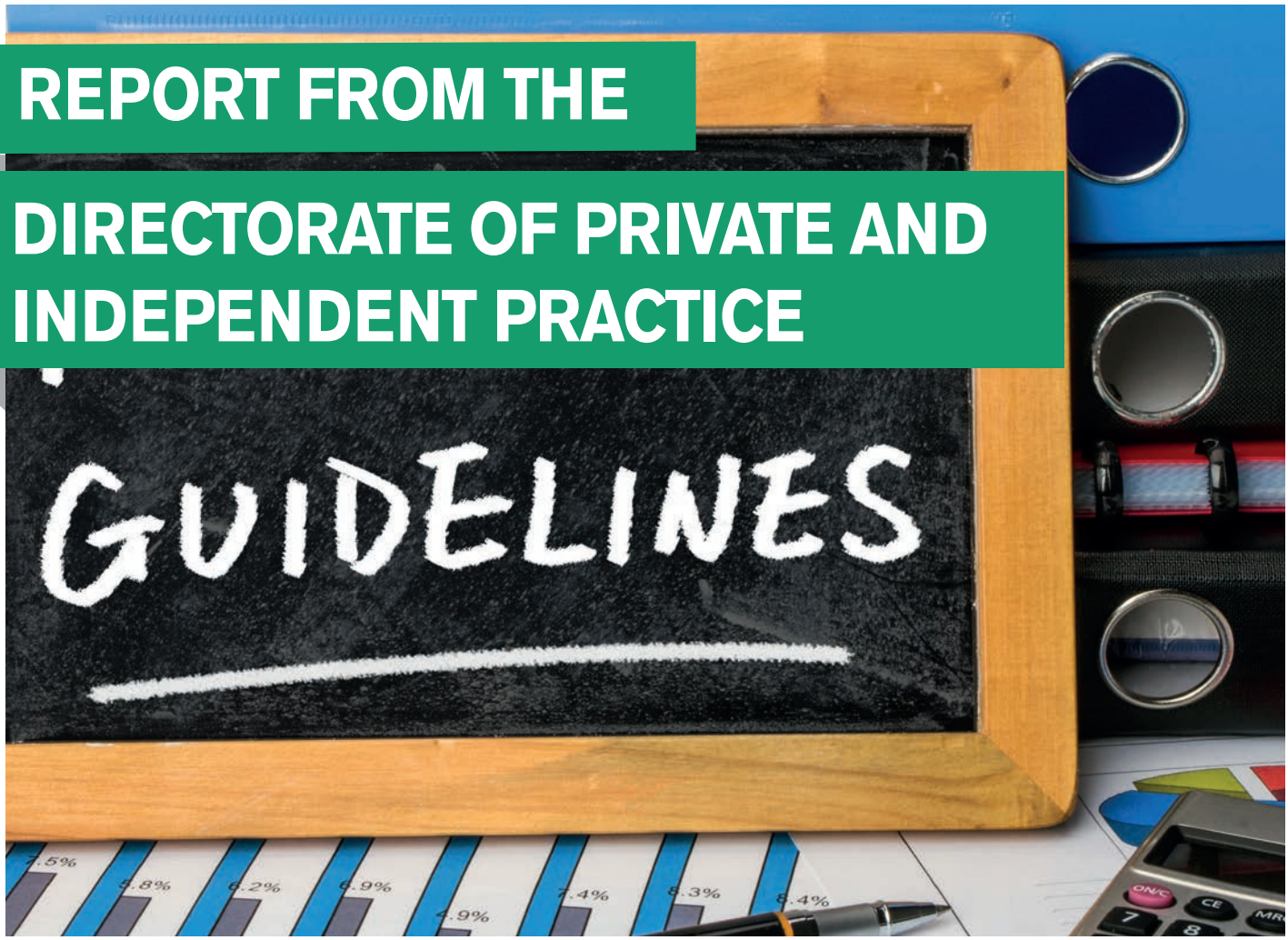
Moreover, I was fortunate to see my supervisors, Associate Professor Cathy Bowen and Dr Lindsey Cherry, present their work and disseminate their expertise. This learning opportunity allowed me to observe all the tips, tricks and pointers discussed in my supervisory meetings.

The exhibition was well attended by health professionals, societies, manufacturers and suppliers with an array of products and career opportunities. There was a chance to network and catch up with those in research, private and NHS posts. Socially, it was lovely to catch up with old friends, mentors and colleagues but also to meet those who have inspired me. I am now intrigued to see what the next 12 months holds for the podiatry profession and would like to thank the Research and Development committee for allowing me to contribute at the conference and to hopefully be a part of improving clinical practice. ■

**CHARLIE DANDO**
**CLINICAL ACADEMIC DOCTORAL RESEARCH FELLOW, UNIVERSITY OF SOUTHAMPTON AND SOLENT NHS TRUST**

> *I HOPE I HAVE ENCOURAGED THE CURIOUS TO EXPLORE THE WORLD OF RESEARCH*

# REPORT FROM THE DIRECTORATE OF PRIVATE AND INDEPENDENT PRACTICE




## The Directorate met in February to discuss ongoing work streams and hear reports from other Committees and Directorates who work closely with us.

**We are finalising the draft guidelines on how members in private and independent practice may apply in their own right to become eligible to be elected as Fellows of the College of Podiatry. These guidelines will be published very soon for members to consider.**

We were given the data from the study commissioned by the College of Podiatry looking at a snapshot of what members (both in private practice and NHS) did in the workplace situation on a given day. This was a well-research report that will be fully presented elsewhere in Podiatry Now and online but suffice to say that it gave us good insights into what members in private and independent practice contribute to the foot health of the population, which is not insignificant.

Allied to this we have our own study into what private and independent practitioners want the College and the Society to do on their behalf. This is currently with the task and finish group to be investigated within this coming year. If any of our members are contacted to participate I would urge your wholehearted support to the researchers in order that we can progress the knowledge base of private and independent practice.

On a different subject we discussed the current situation regarding changes to the funding mechanisms for students accessing podiatry courses. As we are in a state of change it is by no means clear how students will be funded for our courses. A lot of government rhetoric is focused on recruiting more doctors and nurses to supply the NHS, which unfortunately seems to ignore the AHP situation. As such, there could be a reduction in applicants for courses such as ours, which is short sighted to say the least. Successive governments have adopted something of a 'boom or bust' attitude to commissioning for healthcare, which is foolish because the problems patients suffer do not similarly go up and down rather they stay the same or increase.

As members of the same profession it is incumbent on both private practice as well as the NHS members to look after these patients and, as such, the need to have a constant supply of graduates to service both sectors remains constant. As a Directorate we have committed our support to our colleagues in Education to do what we can to encourage people to consider podiatry as a career and to actively promote this in our surgeries. This may be verbal with patients and their families or we may be able to produce a poster to have in the surgery promoting podiatry courses. Most applicants applying to become a podiatrist have at some stage of their life experienced the services of our members or have had close ties with them. ■

**DR ALLAN WOOD**
**DEAN OF THE COLLEGE OF PODIATRY (PRIVATE & INDEPENDENT PRACTICE)**

# HAVE YOUR SAY

If you would like to have your say, please contact us

**Email us:**
podnow@scpod.org

@SCP_PodiatryUK

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**Write to us:**
The Editor,
The Society of Chiropodists & Podiatrists,
Quartz House, 207 Providence Square, Mill Street, London SE1 2EW

**The Editor reserves the right to refuse and to edit responses.**

Things arrive late to the Southern Hemisphere – the February *Podiatry Now* only arrived late this week. I knew that Terry Troy had died – we had a memorial picnic for him at McCallum Park in South Perth last November. His nephew spoke, as did a few other people including Anton Claux; I am fairly certain that they best manned each other. The obituary was true to the letter and Terry was larger than life in every way; while we lived in Perth in the early 1990's Terry and his wife Deb were frequent visitors to our house – particularly if there was food involved! However, the obituary did miss out on one thing – Terry was also a seriously good teacher. While I was the 'orthopaedics tutor' (for want of a better name) in the School of Podiatry at Curtin University, Terry frequently taught orthotic manufacture, cast taking etc. He was very good with students and managed to explain complex issues with simple crystal clarity, cutting straight through all the jargon. We miss you Terry.
**Dr Robert Kidd**
**Barossa Valley, South Australia**

'How to read shoes' (*Podiatry Now* February 2016) was an interesting article which highlighted the value of studying shoes – new and worn ones. As a current student of The Society of Shoe fitters new Footwear and Fitting Course (as publicised in August 2015 issue of *Podiatry Now)* I would like to encourage other podiatrists to enrol on this course. This course provides an insight into the footwear industry, the challenges faced by shoe fitters in the UK today, plus much more. Such a study is a good foundation from which together podiatrists and shoe fitters can endeavour to provide a good foot care service to the public.
**Jacqui Ward**

## BE THE CHANGE YOU WANT TO SEE

I write to express my great pleasure in receiving and reading the March edition of *Podiatry Now*. Seldom, in my experience, has the journal been so interesting and stimulating. I refer in particular to three items which stirred my interest.

The first was the excellent article by E Kannegieter & T Kilmartin reviewing the treatment of plantar 1st joint lesions by sesamoid planing. I am grateful for the inclusion of research back in 1992 on this topic by my team of that date. I continue to use this technique and am pleased to see it endorsed by their work. I would add for further information that my experience has led me never to use the technique in combination with first metatarsal osteotomy. I have found this greatly increases the risks of adhesions and painful joint stiffness.

The second was the re-introduction of the round table discussion, this time on plantar fasciitis. This type of discussion has been tried at conferences but really works better on the printed page. The opportunity to hear from colleagues and their collective experience of treatment regimens and diagnoses is gold dust. One can compare one's own experience and test reliance on treatment algorithms. Please make this an ongoing feature although I have no doubt there is a tremendous amount of background work that was done by Anthony Maher as facilitator especially involving those overseas. CPD at its best.

The last item was the brief report on the development of the MSc in Podiatry at Salford. A most encouraging and exciting new degree, congratulations to Anita Williams and her team. How much more stimulating are these ideas than the negative view we all received in being asked to oppose the changes in student bursaries. The removal of NHS spending on course fees will mean students self-funding so they will be looking for best value courses and no doubt higher degrees will be a serious consideration in their choices. I see the removal of NHS manpower planning as a bonus for improvement in courses approved by the Society and Universities raising the training bar well beyond the threshold of HCPC approval. How about an MSc over four years to include full prescribing rights, theory of podiatric surgery and general practice allowing students to progress straight into surgical training. A practice degree for the 21st century.
**Ralph Graham**

Just to say really enjoyed the round table discussion on Plantar heel pain. Good thought provoking article with great contributions from the panel.
Best clinical picture quiz in a while.
Thank you
**Lorna Hicks**

# BOOK REVIEW


## 50 FOOT CHALLENGES

### ASSESSMENT AND EVIDENCE-BASED MANAGEMENT

Written by:
Thomson, E, C. & Gibson, A, N, J.
2009

Pages:
418

Publisher:
Churchill Livingstone

ISBN-13:
978-0443104022

**HANNAH SCOTT**
**GRADUATE**

***50 Foot Challenges, Assessment and Evidence-Based Management* is a text that aims to provide a structured format for the self-assessment of the reader/user via case studies of numerous conditions that could present within the clinical environment. The book is comprised of 65 case studies, broken down into a series of questions following the format of aetiology, signs, symptoms and treatment methods.**

The purpose of the book – self-assessment - is achieved through the division of the case study and the solution to the study, in order to display to the user gaps in knowledge, which require further research, whilst also consolidating areas of sound clinical knowledge and understanding, thus promoting clinical competence.

This text is suited not only to the podiatry student, once a sound base of clinical knowledge is in place, but also the qualified practitioner seeking continued professional development and wishing to determine areas for research through medical and podiatric journal articles. It could be said that the book is suited to both individual study and group learning with the potential to be utilised within the multidisciplinary environment to strengthen referrals and understanding between different health professionals. *Foot Challenges* bridges the gap between medical textbook and interactive learning aid. This text could become an integral learning tool within the education of future podiatrists where benefits could be particularly noted in the lead up to clinical examination.

The main strengths of the book, within the case studies, are in the ruling out differential diagnoses, in order to enable the user to rationalise and consider conditions alongside one another, and developing and building upon the skill of observing the presenting complaint and patient as a whole and taking into account associated factors, not simply choosing a diagnosis because it fits the picture. The text also reiterates the importance of sound medical history in reaching diagnosis, a part of consultation which is vital. The questions challenge the user to answer 'why' to all points, with the benefit of building upon understanding. It further builds upon its strengths by having a logical, clear and easy to follow question base linking to pictures to provide a visual example for the user, catering for different learning styles.

In addition, Thomson & Gibson provide links to further journal articles at the completion of each case study, thus promoting the reading of medical journals and texts in order to keep up to date with current research. The authors acknowledge that more up to date research may be available, but it is not stated if the articles provided were used in the formation of each case study.

Finally, the key points section within the book equips the reader with the main key learning objectives that should be taken away from each case study and the key words which should make the reader consider this condition within clinical practice. A key strength of this text is in highlighting the importance of correct and appropriate diagnosis.

The addition of the sport injury section highlights a growing trend within the profession and the expansion of the treatment scope for the podiatrist. This section includes surgical intervention techniques, although these would not be conducted by the podiatrist. It could be said that the reader would not have full knowledge of the surgical procedures but having read the solutions to the case studies would be able to provide a general review of expected outcomes to patients/clients. This could be seen as a weakness within the text as it assumes the knowledge of surgical management for all conditions.

The main weakness, however, involves the pictures depicting the conditions. The pictures would benefit from being in colour, enabling the user clearly to assess dermatological skin complaints, borders of ulceration, changes within the tissues of the skin and to differentiate between anatomical structures. To the qualified and experience podiatrist this may not be such a limitation but to the student using this as an educational tool it provides unclear representation of the presenting complaint.

Evidence boxes are used within the text in the solutions of some of the case studies, but there is no reference to which article/journal or text was used to obtain this evidence, which conflicts with the aim of providing evidence-based practice. A simple reference under the evidence box would ensure this.

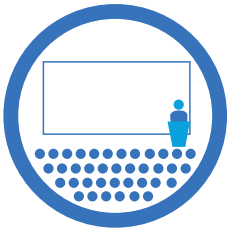
Overall, this text is beneficial, user friendly and challenging. It may contain some conditions and scenarios that the text user will never encounter, such as snake bites, but it covers all of the commonly seen conditions within clinical practice and those that should be considered due to risk of limb loss and impacts on quality of life. Concluding the text with multiple choice questions could be said to be unnecessary due to the volume of questions throughout the text, and it is my opinion that this does not add anything to the quality of the book itself.

To conclude, Thomson & Gibson should be commended on the text and its versatility of use for both the professional and the student alike. Although there are some weaknesses within the book, the strengths outweigh these. Thus, *50 Foot Challenges* is on par with textbooks that have become part of everyday use within both study and the clinical environment and has the potential to benefit all who choose to use the text. ■

# Making the most of your membership

## We will be with you every step of the way

## Just some of the ways we can support you



### Keeping you at the top of your game

Lifelong learning and CPD are pivotal to the development of all podiatrists. The Society has been instrumental in providing you with the tools to stay up to date.

Numerous online CPD learning courses ▪ Comprehensive best practice documents ▪ Network of union learning representatives ▪ Nationwide branch network of podiatrists ▪ Full library of resources on our members-only website ▪ News bulletins delivered straight to your email and through social media channels ▪ Clinical articles and news in Podiatry Now ▪ The largest annual podiatry conference and exhibition in Europe: www.podiatryconference.org

### Promoting the profession and campaigning on behalf of members

Keeping podiatry on the political agenda and influencing Government is one of the Society's highest priorities: we lobby for the better provision and standards of podiatric services and campaign for better employment conditions for all our members.

Promotion of podiatry through extensive PR campaigns, such as Feet for Life Month and Fair Pay Fortnight ▪ Representation at the Department of Health, the NHS Staff Council, the NHS Pay Review Body, NHS Social Partnership Forum within England, Scotland, Wales and Northern Ireland ▪ Regular contact with the HCPC on registration and professional issues ▪ Representation in Europe and internationally through Federation of International Podiatrists (FIP) and the European Federation of Public Sector Unions (EPSU) ▪ Influencing the European Parliament through the TUC and EPSU ▪ Successful campaigning for independent prescribing for podiatrists ▪ Engaging with other Allied Health Professions to promote the profession.

### Keeping you updated throughout your career

We are committed to promoting high standards of education and development to keep you clinically up to date.

CPD courses run by both the Society and local branches ▪ Student and new graduate support ▪ Links with affiliated organisations and special interest groups covering every aspect of podiatry ▪ Continual research and development projects in many areas of podiatry ▪ Regular postgraduate education meetings and courses ▪ Access to Fellowship programmes leading to advanced practice, including podiatric surgery ▪ Access to a range of learning resources through the Society's Union Learning Fund ▪ Over 100 speakers at the College of Podiatry annual conference ▪ 50% discount on e-learning modules via the Society website ▪ Education quality assurance ▪ Regular CPD in Podiatry Now, and peer-review articles in the Journal of Foot and Ankle Research (JFAR).


### Marketing and supporting our members

Whichever area of podiatry you work in, promoting yourself is important on a personal and business level. The Society has as a range of resources designed specifically to help you.

Network of 50 Society branches: great for local support and networking ▪ Courses and conferences: keeping you updated on latest thinking and trends ▪ The private practice handbook: the bible on running your podiatry business ▪ Support throughout your working life: we are here to advise you what ever your query ▪ Free "Find a Podiatrist" listing on www.feetforlife.org: we will promote your practice to the general public ▪ Private practice support: need help running your business? Then look no further, we have a wide range of resources including a comprehensive area on the website ▪ Practice accreditation: promote your practice as being the gold standard ▪ Peer-to-peer networks: we have dozens of specialist groups that cover all aspects of podiatry ensuring what ever your interest there are like minded individuals out there to help you.

# COURSES & EDUCATION

➔ Cost: £50 per course per month, with discounts for bookings for six consecutive months or more. Entries are free of charge to SCP Branches and recognised Special Advisory Groups.
For more information contact Tina Davies on 020 7234 8639 or Email: courses@scpod.org for a course form

**JUNE 2016 DEADLINE: MIDDAY 22 APRIL 2016**

## 2016 DEADLINES

| Issue | Deadline | Publication date |
|---|---|---|
| JUNE | 22 APRIL | 20 MAY |
| JULY | 27 MAY | 20 JUNE |
| AUGUST | 17 JUNE` | 20 JULY |

## CATEGORIES

- Basic Life Support
- Biomechanics
- Chronic Wounds / Wound Healing
- Clinical Education
- Complementary therapy
- Dermatology
- Diabetes
- Diagnostic Imaging
- Injection Control
- Injection Therapy
- Local Analgesia
- Manipulation
- Mobilisation
- Musculoskeletal
- Neurology
- Pharmacology
- Podopaediatrics
- Rheumatology
- Surgery
- Vascular Assessment
- Other

If you would like your course(s) or forthcoming event(s) to be advertised in *Podiatry Now*, please complete this form and return to the SCP. Ideally, please send in your details at least four months before the event to ensure that it appears in at least two journal issues.

➔ Title: .....

.....

➔ Venue: .....

➔ Date(s): .....

➔ Cost: .....

➔ Duration (Hours): .....

➔ CPD Points: ..... (1 hour of lecture time equals 1 CPD Point)

➔ Category (see list below): .....

➔ Contact Name: .....

➔ Contact Address: .....

.....

➔ Contact Telephone: .....

➔ Contact Fax: .....

➔ Contact Email: .....

➔ Name (in block capitals): .....

.....

➔ Date: .....

Please return this form, together with payment and a copy of your course programme, to The Marketing and Communications Assistant, The Society of Chiropodists and Podiatrists, Quartz House, 207 Providence Square, Mill Street, London SE1 2EW or tel: 020 7234 8639.

| Title | Venue | Date | Cost | CPD Points | Contact |
|---|---|---|---|---|---|
| **Basic Life Support** | | | | | |
| ★ Basic Life Support | The Bell Surgery, Manchester | 18 June 2016 | £80 | 5 | Nigel and Morag Bell,<br>The Bell Surgery Ltd,<br>453 Barlow Moor Road,<br>Chorlton,<br>Manchester M21 8AU<br>Tel.: 0161 881 2128<br>Email: information@thebellsurgery.com |
| **Biomechanics** | | | | | |
| PPL Biomechanics Confidence Boosting Biomechanical Assessment & Prescription writing course | Royal Marine Hotel, Marine Road, Dun Laoghaire | 20 & 21 May 2016 | €325 full price. €300 early bird if booked and paid for before April 20th. Recent gradute & group discounts | 14 | Sarah Fox,<br>PPL Biomechanics,<br>Tramore Commercial Park,<br>Tramore Park,<br>Cork, Ireland.<br>Tel: 00353 21-4320277 |
| Assessment, Evaluation and management of lower limb sports injuries with Trevor Prior | York St John University, York | 24 September 2016 | £75 | 7 | Judith Barbaro-Brown, Head of Programme Interdisciplinary CPD,<br>Department of Occupation & Wellbeing,<br>Faculty of Health and Life Sciences,<br>York St John University,<br>Lord Mayor's Walk,<br>York YO31 7EX<br>Email: hlscpd@yorksj.ac.uk<br>www. yorksj.ac.uk/healthcpd |
| **Chronic Wounds/Wound Healing** | | | | | |
| Chronic Wounds & Wound Healing | York St John University, York | 15 October 2016 | £65 | 7 | Judith Barbaro-Brown, Head of Programme Interdisciplinary CPD,<br>Department of Occupation & Wellbeing,<br>Faculty of Health and Life Sciences,<br>York St John University,<br>Lord Mayor's Walk,<br>York YO31 7EX<br>Email: hlscpd@yorksj.ac.uk<br>www. yorksj.ac.uk/healthcpd |
| ★ Wound and Larval Debridement Therapy e-Learning courses | Online | Online | FREE | 5 | To access course materials, visit www.larvalacademy.com/demo/<br>For any issues contact Kris Flynn (Biomonde) on: kflinn@biomonde.com |
| **Complementary Therapy** | | | | | |
| ★ Practical Acupuncture for podiatrists including dry needling | Venue: Merlin Park Podiatry Clinic, Unit 3, Merlin Park Hospital, Dublin Road, Galway, Ireland | 1-3 Oct 2016 | Fee: €900 (Early Bird €850 before 31/8/2016)<br>Full Time Student: €450 (Early Bird €425 before 31/8/2016) | 26 | Courses delivered by Shane Toohey<br>To book, ring Algeos:<br>Tel: 0151 448 1228<br>or book online at Algeos website:<br>www.ALG-academy.com |

**Disclaimer:** Society accredited courses are denoted by ★. Members who undertake and successfully complete these are covered by the Society's insurance scheme for the extention to their scope of practice. Courses of general interest and those covering advances or modifications of recognised podiatric practice do not require formal accreditation. Members practising any techniques acquired during study of other courses which significantly extend their scope of practice may fall outside the insurance cover. In such cases, members are advised to ensure that they have made alternative arrangements for insurance cover before extending their scope of practice. For queries regarding courses or events please contact course organiser directly.

| Title | Venue | Date | Cost | CPD Points | Contact |
|---|---|---|---|---|---|
| Foundation in Acupuncture Course | London | 7 – 8 May 2016<br>18 – 19 June 2016 | £395 | 80 | Steve Bailey,<br>The School of Biomechanics, Sports and Remedial Therapies.<br>76 Derby Road,<br>Long Eaton,<br>Nottingham NG10 4LB<br>Tel: 0115 983 5780<br>Email: enquiries@sobsart.com |
| An Osteopathic Look at the Foot for Purpose | Ye Olde Plough House Brentwood Road, Bulphan Essex RM14 3SR | 30 June 2016 | £70 | 5 | Course Leaders - Osteopaths Jamie Lauder & Greg Barker<br>Book via scp-seb.yapsody.com<br>Enquiries to Claire.bland@btconnect.com<br>Closing date 20th June 2016 |
| ★ Introductory Podiatric Acupuncture course | 275 Borough High Street. London SE1 | 16 July 2016 (Part 2) | £370 | 30 | Dr Anthony Campbell,<br>8 Oak Way,<br>London N14 5NN<br>Tel: 0208 368 3418<br>Email: camanthony@gmail.com |
| Reflexology Certificate Course | The Holistic Coach House, Carrick House, 2 The High Street, Garstang, Preston PR3 1FA | Various held over 3/4 days | £450 | 24 plus min 30 post course | Jillian Edmundson<br>Carrick House,<br>2 The High Street,<br>Garstang,<br>Preston PR3 1FA<br>Tel: 01524791126/07411018541 |
| **Dermatology** | | | | | |
| ★ Dermatology Update Course | The Bell Surgery, Manchester | 17 Sep 2016 | £80 | 5 | Nigel and Morag Bell<br>The Bell Surgery Ltd<br>453 Barlow Moor Road<br>Chorlton<br>Manchester M21 8AU<br>Tel: 0161 881 2128<br>Email: information@thebellsurgery.com |
| **Diagnostic Imaging** | | | | | |
| Diagnostic Imaging | York St John University, York | 25 June 2016 | £65 | 7 | Judith Barbaro-Brown, Head of Programme Interdisciplinary CPD,<br>Department of Occupation & Wellbeing,<br>Faculty of Health and Life Sciences,<br>York St John University,<br>Lord Mayor's Walk,<br>York YO31 7EX<br>Email: hlscpd@yorksj.ac.uk<br>www. yorksj.ac.uk/healthcpd |
| **Injection Therapy** | | | | | |
| ★ Introduction to Cortiosteroid Injection Therapy | Cripps Postgraduate Medical Centre, Northampton General Hospital | 5-6 Nov 2016 | £395 includes tuition, course notes, lunch & refs | 15 | Ian Reilly; Consultant Podiatric Surgeon<br>BMI Three Shires Hospital<br>The Avenue, Cliftonville<br>Northampton. NN1 5DR<br>Tel: 07952 051886<br>@: info@podsurgeon.co.uk |

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| Title | Venue | Date | Cost | CPD Points | Contact |
|---|---|---|---|---|---|
| **Local Analgesia** | | | | | |
| ★ Local Analgesia Update Course | The Bell Surgery, Manchester | 21 May 2016 | £80 | 5 | Nigel and Morag Bell,<br>The Bell Surgery Ltd,<br>453 Barlow Moor Road, Chorlton,<br>Manchester M21 8AU<br>Tel.: 0161 881 2128<br>Email: information@thebellsurgery.com |
| **Mobilisation/Manipulation** | | | | | |
| ★ Foot Mobilisation | Edinburgh - Marriott Hotel | 21-22 May 2016 | £399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techiniques) | 36 CPD Points (+5 hours reading) | Courses delivered by Ian Linane<br>To book, ring Algeos:<br>Tel: 0151 448 1228<br>or book online at Algeos website:<br>www.ALG-academy.com |
| ★ Foot Mobilisation | Cardiff - Marriott Hotel | 11-12 June 2016 | £399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques) | 36 CPD Points (+5 hours reading) | Courses delivered by Ian Linane<br>To book, ring Algeos:<br>Tel: 0151 448 1228<br>or book online at Algeos website:<br>www.ALG-academy.com |
| ★ Foot Mobilisation | Derby - Marriott Breasdale Priory | 16-17 July 2016 | £399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques) | 36 CPD Points (+5 hours reading) | Courses delivered by Ian Linane<br>To book, ring Algeos:<br>Tel: 0151 448 1228<br>or book online at Algeos website:<br>www.ALG-academy.com |
| ★ Soft tissue mobilisation | Bristol - Marriott Bristol Royal | 10-11 Sept 2016 | £399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments) | 36 CPD Points (+5 hours reading) | Courses delivered by Ian Linane<br>To book, ring Algeos:<br>Tel: 0151 448 1228<br>or book online at Algeos website:<br>www.ALG-academy.com |
| ★ Ankle Mobilisation | Manchester Centre - Marriott Renaissance | 24-25 Sept 2016 | £399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques) | 36 CPD Points (+5 hours reading) | Courses delivered by Ian Linane<br>To book, ring Algeos:<br>Tel: 0151 448 1228<br>or book online at Algeos website:<br>www.ALG-academy.com |
| ★ Ankle mobilisation | Glasgow - Marriott | 8-9 October 2016 | £399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques) | 36 CPD Points (+5 hours reading) | Courses delivered by Ian Linane<br>To book, ring Algeos:<br>Tel: 0151 448 1228<br>or book online at Algeos website:<br>www.ALG-academy.com |
| ★ Ankle Mobilisation | Portsmouth - Marriott | 15-16 October 2016 | £399.95 (incl. VAT, pre-reading material, course manual, lunch & refreshments, and videos of techniques) | 36 CPD Points (+5 hours reading) | Courses delivered by Ian Linane<br>To book, ring Algeos:<br>Tel: 0151 448 1228<br>or book online at Algeos website:<br>www.ALG-academy.com |

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| Title | Venue | Date | Cost | CPD Points | Contact |
|---|---|---|---|---|---|
| **Pharmacology** | | | | | |
| Pharmacology with Local Analgesia Update | York, St John University | 16 July 2016 | £65 | 7 | Judith Barbaro-Brown, Head of Programme Interdisciplinary CPD, Department of Occupation & Wellbeing, Faculty of Health and Life Sciences, York St John University, Lord Mayor's Walk, York YO31 7EX Email: hlscpd@yorksj.ac.uk www. yorksj.ac.uk/healthcpd |
| ★ Pharmacology Update | The Bell Surgery, Manchester | 5 November 2016 | £80 | 5 | Nigel and Morag Bell, The Bell Surgery Ltd, 453 Barlow Moor Road, Chorlton, Manchester M21 8AU Tel.: 0161 881 2128 Email: information@thebellsurgery.com |
| **Vascular assessment** | | | | | |
| ★ Dimension in a Day- Lower Limb Vascular Assessment' | SCP offices, Quartz House, Providence Square, London | 7 October 2016 | £230. Discounts offered on block bookings | 7 | Please book via EventBrite or contact Joanne McCardle & Paul Chadwick at pjdimensions@hotmail.com |
| **Other** | | | | | |
| Pulse Palpatation/Life Preservation | Sherwell Centre, Plymouth University | 15 June 2016 | Earlybird £55 (before 1/5/16) and then £65 | 6 | Sally Abey, FF15, PAHC, Marjon Campus, Derriford Road, Plymouth, Devon PL6 9BH Tel: 01752 588839 Email: sabey@plymouth.ac.uk |

# CALL FOR DELEGATES FOR TUC CONFERENCES IN 2016

**We are looking for two delegates to attend each of the following TUC Conferences:**

| | | |
|---|---|---|
| TUC Disabled Workers Conference | 19-20 May 2016 | Congress House, London |
| TUC LGBT Conference | 23-24 June 2016 | Congress House, London |

Your role as a delegate will be to listen to the debates and represent the Society for your time at the conference and if possible form a motion to put to the Conference. The Society will also pay for expenses and organise any hotel accommodation.
If you are interested and would like to be considered, please contact Natasha Smith in the Employment Relations Department on **020 7234 8633** or **ns@scpod.org**

## SOUTH ESSEX BRANCH

**Friday 9th September (Closing date 24th Aug)**
**Ye Olde Plough House, Brentwood Road (A128), Bulphan, Essex RM14 3SR**

**MANAGING THE DIFFICULT PATIENT**
**With Ches Moulton DHP C Ht CSH**

**Anxiety Based Disorders (ABD)**
**Aggressive and Violent Patients**
**Practice Environment and the Impact on the Patient**
**Communication & Language and Patients with Negative Mental Health Issues**
**Treatment Plan Compliance - Helping the Unmotivated Patient "get on side"**
**Autistic Spectrum Disorder**
**Cost £70**
**Book via scp-seb.yapsody.com**

**8.30-9.00 Early bird breakfast***
**9.00-9.30 Registration**
**9.30-17.00 Course**
**Lunch & refreshments provided**
***On a first come first served basis**

## CAMBRIDGE BRANCH
### SOCIETY OF CHIROPODISTS & PODIATRISTS

**Dermatology CPD Update - 19 June 2016**

**Full Day 9:00 - 4:30**
**Speaker:**
**Judith Barbaro-Brown**
**Cost: £50**
**Venue:**
**Holiday Inn Cambridge**
**Bridge Road, Impington**
**Cambridge CB4 9PH**

**Itinerary:**

- **08:30 - Registration**
- **09:00 - Introduction**
- **09:00 - Revision skin structure & function - Neoplasm, Benign or malignant? Dermatological presentations of systemic disease (diabetes, RhA, renal, lupus etc)**
- **12:30 - Lunch**
- **1:30 - Canonbury (tbc)**
- **2:30 - Autoimmune dermatological conditions, (psoriasis, vitiligo, scleroderma etc)**
- **4:30 - Close**

**More information from: www.facebook.com/groups/cambridgescp/**
**Tickets available from:**
**www.eventbrite.co.uk/e/dermatology-update-tickets-21787843025**

## ATTENTION BRANCHES!

All branches get 3 free 1/4 display adverts per year. If you have your own design with images then please just email these to Diary@scpod.org or courses@scpod.org

These adverts are a great opportunity to draw attention to your courses or events.

## BUCKINGHAMSHIRE BRANCH

**4th June 2016**

**Annual Study Day – LA and Pharmacology update (9am – 5pm) £80**

**VENUE**
**Floyd Auditorium, Education Block, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL**

**Paul Adams: pja_ad@yahoo.co.uk**
**Please make cheques payable to SoCaP Bucks Branch & send to:- Paul Adams, 15 Meadow Drive, Amersham, Bucks. HP6 6LB.**

**If a receipt is required, please send a stamped addressed envelope with payment.**

## SOUTH YORKSHIRE BRANCH MEETING/EDUCATION

**VENUE: THE HOLIDAY INN, HIGH ROAD, WARMSWORTH, DONCASTER, DN4 9UX**
**CONTACT: Janet Cawthorne, Jane Senior**
**Email: greensidepod@hotmail.co.uk Tele No: 01226 388622/384135**

**JANET CAWTHORNE ULR/ EDUCATION OFFICER-EDUCATION NEWS UPDATE FOR SOUTH YORKSHIRE BRANCH**

**6th June 2016 – Vascular Assessment Update by Jean Mooney**
**9.15-9.45 am Registration/Refreshments, 10am-4pm Educational Session.**

**5th September 2016 – Neurological Update by Jean Mooney**
**9.15-9.45 am Registration/Refreshments, 10am-4pm Educational Session.**
**3rd October 2016 – Intermediate level – Cardiopulmonary Resuscitation CPR/Automated External Defibrilation/Anaphylaxis**
**Course 1 Refreshments and Registration 9.15-9.30am, Course 9.30am-12.30pm**
**Course 2 Refreshments/Registration 1.15-1.30pm, Course 1.30-4.30pm.**

**£60.00 to pay for cost of training, cheques to be made payable in full name of Society of Chiropodists and Podiatrists South Yorkshire Branch.**

## NEWCASTLE UPON TYNE BRANCH

Local Anathesia Update
With Dr Sharon Rees

Sunday 8th May 2016

9 30 am to 4 00pm

At The Falcons Rugby Club
Kingston Park
Newcastle upon Tyne
NE13 8AF

The venue has on site parking and is easily accessed from the A1, Newcastle airport and from the central station via the metro.

Cost £50 to include light lunch.

Book through Eventbrite at www.eventbrite.co.uk/e/la-update-tickets-21475553960

Any Enquiries to Branch Secretary
Hazel Childs
Hazepod@aol.com
0191 3732836

# DO YOU WANT TO WRITE FOR PODIATRYNOW?

Podiatry Now is published each month, to bring news and information to members. To ensure that we include the right information we need you to tell us what is happening in podiatry.

- Have you run a successful Branch meeting with guest speakers, or arranged a Branch social event?
- Do you belong to a Special Interest Group and would like to let others know about what you are doing?
- Has your Trust or Health Authority organised any events that may be of interest to other members?
- Have you, personally, achieved something within the profession that you would like to tell others about?
- Do you have any tried and tested tips or ideas that you would like to share?
- Or would you simply like to comment on anything that we have already published?

Any items that you would like to be considered for publication should be sent to:

Clare Richards, Editor
Tel: 0845 450 3738; email: podnow@scpod.org

# DATES FOR YOUR DIARY

➔ Entries into these pages are free of charge to Society branches and groups. Please submit entries as far ahead as possible, giving date, group, basic details and a contact name and phone number. Any amendments/new dates to be highlighted clearly. Due to space constraints, events are usually publicised no more than three months ahead. Email: diary@scpod.org with your diary dates

## APRIL 2016

### 23 – MANCHESTER AND DISTRICT BRANCH

Diabetic Foot Studies Day. 9am-4pm. Cheadle Village Hotel, Cheadle Road, Cheadle, Stockport, Greater Manchester SK8 1HW. AM – Presentations: Paul Chadwick, Frances Game, Frank Webb, Sarah Matthews, Pam Smith. PM – Choice of 2 of 4 workshops. Lunch & refreshments included. Free parking. Book via Eventbrite £55 + booking fee. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

### 23 – BUCKINGHAMSHIRE BRANCH

The Podiatry Business Masterclass - Podiatry Hive Study Day - Early bird discount (£30) £60 after 16th March 2016 (Study Day 9am - 5pm). Floyd Auditorium, Education Block, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL. Contact details for the above courses and CPD events: Paul Adams: pja_ad@yahoo.co.uk

### 26 – GUILDFORD BRANCH

June Ewart, Tissue Viability Specialist. (TVS) - Tissue viability & practical wound care management. Venue: Oak Room, Mandolay Hotel, 36-40 London Rd, Guildford, GU1 2AE. 7.30pm for a prompt 8pm start. Open to non-members £15. For information please contact socapguildford@gmail.com

### 26 – EAST SUSSEX BRANCH

Chronic Lymphoedema and Management. Speaker: Anna Colbourn, Activa Healthcare. Held at Dept. of Podiatry, University of Brighton Leaf Hospital, St Anne's Road, Eastbourne, unless otherwise stated. Meetings start at 7.15pm, doors locked by 7.35pm. For further details please contact Lesley Baker: labaker@btopenworld.com or 01323 764393.

## MAY 2016

### 4 – GLASGOW BRANCH

Topic and speaker tbc. All meetings will be held at the Students Association, Glasgow Caledonian University, Cowcaddens Road, Glasgow, G4 0BA with a start time of 7.15pm. For further details please contact glasgowbranchsecretary@googlemail.com

### 4 – LONDON DISTRICT BRANCH

Cuxson Gerrard - Structure and function of the spring ligament and posterior tibial tendon function and dysfunction. Please arrive from 7pm onwards for 7.30pm start. All lectures held at Park Crescent Conference Centre, Great Portland Street, opposite Great Portland St tube station. Refreshments provided. For further details please contact Steven Childs on londondistrictbranch.scp@gmail.com or 07846764394 or register on Eventbrite at www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190965587. Please also visit our Facebook page 'London District'

### 4 – LANCASHIRE BRANCH

Health & Safety: Covering Safe Lone-Working, RSI & Stress. Delivered by Graham Pirie, Society of Chiropodists & Podiatrists. Time: 6.30pm-9.00pm. Venue: Leyland Best Western Hotel, Leyland Way, Leyland, PR25 4JX. Cost: £12.50 for SCP members / students £3.00. Email: scplancashirebranch@gmail.com or search for "Lancashire Branch of the Society of Chiropodists/Podiatrists" on Facebook.

### 8 – NEWCASTLE UPON TYNE BRANCH

Local Anaesthesia Update. With Dr Sharon Rees. Time: 9 30 am to 4 00pm. At The Falcons Rugby Club, Kingston Park, Newcastle upon Tyne, NE13 8AF. The venue has on-site parking and is easily accessed from the A1 Newcastle airport and from The Central station via the metro. Cost £50 to include light lunch. Book through Eventbrite at https://www.eventbrite.co.uk/e/la-update-tickets-21475553960 Enquiries to Branch Secretary, Hazel Childs Hazepod@aol.com or tel: 0191 3732836.

### 9 – SOUTH ESSEX BRANCH

Meeting followed by a talk from Nutritionist Sarah Hurst on Diabetes, Hypothyroidism & Cholesterol. Venue: Ye Olde Plough House, Brentwood Road (A128), Bulphan RM14 3SR. Time 19.30 – 21.30pm. Drinks available at the bar. Cost – FREE. RSVP by 25th April 2016 to scp-seb.yapsody.com

### 10 – EAST RIDING OF YORKSHIRE BRANCH

Time: 7.00 pm. Duke of Cumberland Pub in Cottingham. Radiography of the Foot - Nick Crohn, Leeds General Infirmary Radiographer and Lecturer. Contact Helen Keough. Email: keough@keough.karoo.co.uk

### 10 – THE SOCIETY OF CHIROPODISTS & PODIATRISTS

10.30 am - Employment Relations Committee. Contact Maureen Jonas on 0207 234 8631.

### 11 – GREATER MANCHESTER PRIVATE PRACTICE NETWORK

All podiatrists are welcome to attend. Topic: Neurology Talk with Alison Edmonds-Nicholson from Manchester Neurotherapy Centre (MNC). Venue: Manchester Maccabi Community & Sports Club, Brooklands, Bury Old Road, Prestwich, M25 0EG at 7.30pm. Contact: Lindsey 07575285815. Booking Essential. Early bird price available. To book log onto www.manchesterpodppn.eventbrite.co.uk

**JUNE DEADLINE: MIDDAY 29 APRIL**

**12 – KINGSTON & SOUTH LONDON BRANCH**
Swift – New Microwave treatment of verrucae with Jonathon Williams, 8pm. Venue: Post Graduate Medical Centre, St Helier Hospital, Carshalton, SM5 1AA. Contact: secretary@kslbranch.co.uk

**18 – MID SUSSEX BRANCH**
7pm for 7.30pm start at Haywards Heath Town Hall, Boltro Road, Haywards Heath. Record keeping. Speaker, Caroline Godfrey (solicitor from Mayo Wynn Baxter Solicitors). Please confirm your attendance by email: mid-sussex.socap@gmail.com

**18 – MANCHESTER & DISTRICT BRANCH**
CPD: Homeopathy. With Manu Mistry. 7.30pm at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX Free to Society members/students - PLEASE bring proof of Society membership/student card. Tea/coffee provided. Trade support: Foot essentials. No need to book, just turn up. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

**18 – LANCASHIRE BRANCH**
Basic Life Support & Anaphylaxis Update. Delivered by Michael Harrison-Blount. Time: 6.45pm-9.15pm. Venue: Leyland Best Western Hotel, Leyland Way, Leyland, PR25 4JX. Cost: £45 for SCP members. Email: scplancashirebranch@gmail.com or search for "Lancashire Branch of the Society of Chiropodists/Podiatrists" on Facebook.

**18 – BUCKINGHAMSHIRE BRANCH**
Langer Presentation (Evening Branch CPD: 7 30 - 9 pm) at the Duke of Edinburgh Education Block, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL. Please make cheques payable to SOCAP Bucks Branch & send to: Paul Adams, 15 Meadow Drive, Amersham, Bucks. HP6 6LB. If a receipt is required please send a stamped addressed envelope with payment. Contact details for the above courses and CPD events: Paul Adams: pja_ad@yahoo.co.uk

**20 – THE COLLEGE OF PODIATRY**
10.30 am - Committee of the Directorate of Podiatric Surgery meeting. Contact Kim Bryant 020 7234 8627.

**21 – THE COLLEGE OF PODIATRY**
10.30 am - Committee of Private Practice and Committee of the Directorate of Independent Practice. Contact Maureen Jonas on 0207 234 8631.

**24 – EAST SUSSEX BRANCH**
Parkinson's and the effects on the lower limb. Speaker: Mike Scott, Parkinson's Nurse Specialist for East Sussex Healthcare NHS Trust. Held at Dept. of Podiatry, University of Brighton Leaf Hospital, St Anne's Road, Eastbourne, unless otherwise stated. Meetings start at 7.15pm, doors locked by 7.35pm. For further details please contact Lesley Baker: labaker@btopenworld.com or 01323 764393.

**26 – THE SOCIETY OF CHIROPODISTS & PODIATRISTS**
10.30 am - Professional Practice Committee. Contact Maureen Jonas on 0207 234 8631.

**31 – GUILDFORD BRANCH**
Jonathan Williamson, Director, Strategy & Marketing Microwave Emblation SWIFT Presentation on An Introduction to Swift: Microwave Therapy for Skin. Venue: Oak Room at the Mandolay Hotel, 36-40 London Rd, Guildford GU1 2AE. 7.30pm for a prompt 8pm start. Open to non-members £15. For information, please contact socapguildford@gmail.com

## JUNE 2016

**1 – LONDON DISTRICT**
Ina Farrelly, podiatrist. Talk on Lymphoedema. Nail Surgery CPD Update planned for September 2016. Please arrive from 7pm onwards for 7.30pm start. All lectures held at Park Crescent Conference Centre, Great Portland Street, opposite Great Portland St tube station. Refreshments provided. For further details please contact Steven Childs on londondistrictbranch.scp@gmail.com or 07846764394 or register on Eventbrite at www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190965587. Please also visit our Facebook page 'London District'

**4 – BUCKINGHAMSHIRE BRANCH**
Branch study day - LA and Pharmacology Update with Jean Mooney. Please arrive 8.45 for 9am - 5.00pm. Venue: Floyd Auditorium, Education Block, Stoke Mandeville Hospital, Aylesbury HP21 8AL. Canonbury stall. Please send cheque for £80.00 payable to SOCAP to Paul Adams 15 Meadow Drive, Amersham Bucks HP6 6LB. Contact details for the above courses and CPD events: Paul Adams: pja_ad@yahoo.co.uk

**6 – BRENT PRIVATE PRACTICE NETWORK**
Fungal nail treatments with a demonstration by Flexitol. Venue: The Preston Pub, 161 Preston Road, Wembley HA9 8NG. Meetings start at 7.30pm. All podiatrists welcome. Email diana_ayres@hotmail.com or tel: 0780 6419940.

**6 – BRENT PRIVATE PRACTICE NETWORK**
Sterilisation and decontamination by Margaret Johns. Venue: Preston Pub, 161 Preston Road, Wembley HA9 8NG. Meetings start at 7.30pm. All podiatrists welcome. Email diana_ayres@hotmail.com or tel: 0780 641 9940.

**6 – SOUTH YORKSHIRE BRANCH**
Vascular Assessment Update by Jean Mooney. Time: 9.15-9.45 am for Registration/Refreshments, 10am-4pm Educational Session. CONTACT: Janet Cawthorne, Jane Senior. Email: greensidepod@hotmail.co.uk Tel: 01226 388622/384135.

**7 – NEWCASTLE UPON TYNE BRANCH**
Meeting at The Novotel, Kingston Park at 7.30 pm. Talk by Michael Ratcliff former head of the Birmingham School of Podiatry. "Functional and Dysfunctional Anatomy of the heel fat pad." Diagnosis and Treatment of this often unrecognised condition. **Please note the new venue.** For further information contact Hazel Childs Branch Secretary hazepod@aol.com

**7 – GREATER MANCHESTER PRIVATE PRACTICE NETWORK**
All podiatrists are welcome to attend. Topic: Pharmacology Talk with Mr A.L. Murphy (Consultant Podiatric Surgeon). Venue: Manchester Maccabi Community & Sports Club, Brooklands, Bury Old Road, Prestwich, M25 0EG at 7.30pm. Contact: Lindsey 07575285815. Booking Essential. Early bird price available. To book log onto www.manchesterpodppn.eventbrite.co.uk

**8 – LANCASHIRE BRANCH**
Defibrillator Training Delivered by Michael Harrison-Blount. Delegates MUST attend the necessary Basic Life Support Training Event (provided by Michael Harrison-Blount) prior to attending this event. Time: 6.45pm-9.15pm. Venue: Leyland Best Western Hotel, Leyland Way, Leyland, PR25 4JX. Cost: £12.50 for SCP members. Email: scplancashirebranch@gmail.com or search for "Lancashire Branch of the Society of Chiropodists/Podiatrists" on Facebook.

**12 – GRAMPION BRANCH**
Speaker - Mr Neil Forrest, Consultant Trauma and Orthopaedic Surgeon. Topic to be confirmed. Time: 9am registration for 9.30 start till 12.30/1pm. The Aberdeen Altens Hotel, Souterhead Road, Aberdeen, AB12 3LF. Contact: Grampian SOCAP: grampiansocap@live.co.uk

**15 – MID SUSSEX BRANCH**
7pm for 7.30pm start at Haywards Heath Town Hall, Boltro Road, Haywards Heath. TBC. Please confirm your attendance by email midsussex.socap@gmail.com

**15 – MANCHESTER & DISTRICT BRANCH**
June extra CPD: HCPC Audit – How to prepare & what to do if you are selected. With Graham Holt. Time 7.30pm at Hough End Centre, Mauldeth Road West, Chorlton, M21 7SX. Free to Society members/ students - PLEASE bring proof of Society membership/student card. Tea/coffee provided. No need to book, just turn up. Contact Manchester Branch for details: scpmanchesterbranch@gmail.com

**22 – LANCASHIRE BRANCH**
Basic Life Support & Anaphylaxis Update. Delivered by Michael Harrison-Blount. Time: 6.45pm-9.15pm. Venue: Leyland Best Western Hotel, Leyland Way, Leyland, PR25 4JX. Cost: £45 for SCP members. Email: scplancashirebranch@gmail.com or search for "Lancashire Branch of the Society of Chiropodists/Podiatrists" on Facebook.

**28 – GUILDFORD BRANCH**
Paul Halliwell, Orthopaedic Surgeon. Presentation on Chronic ankle injuries and what to do about them. Venue: Oak Room at the Mandolay Hotel, 36-40 London Rd, Guildford GU1 2AE. Time: 7.30pm for a prompt 8pm start. Open to non-members. £15. For information, please contact socapguildford@gmail.com

## JULY 2016

**6 – LONDON DISTRICT BRANCH**
Rodney Fawkes - Epidermolysis Bullosa. For further details contact Steven Childs on londondistrictbranch.scp@gmail.com or 07846764394 or register on Eventbrite at www.eventbrite.co.uk/e/ldb-evening-meeting-tickets-15190965587. Please visit our Facebook page 'London District'

**19 – EAST SUSSEX BRANCH**
Lupus – the wolf in sheep's clothing. Speaker Simon Otter. Held at Dept. of Podiatry, University of Brighton Leaf Hospital, St Anne's Road, Eastbourne, unless otherwise stated. Meetings start at 7.15pm, doors locked by 7.35pm. For further details please contact Lesley Baker: labaker@btopenworld.com or 01323 764393.

**19 – KINGSTON & SOUTH EAST BRANCH**
Wound Healing and Dressings in Podiatry By Kimberly Kirkwood, Diabetes Specialist Podiatrist, 8pm. Venue: Post Graduate Medical Centre, St Helier Hospital, Carshalton, SM5 1AA. Contact: secretary@kslbranch.co.uk

**20 – BUCKINGHAMSHIRE BRANCH**
The Society of Shoe Fitters (Evening Branch CPD: 7 30 - 9 pm) at the Duke of Edinburgh Education Block, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL. Please make cheques payable to SOCAP Bucks Branch & send to:- Paul Adams, 15 Meadow Drive, Amersham, Bucks. HP6 6LB. If a receipt is required, please send a stamped addressed envelope with payment. Contact details for the above courses and CPD events: Paul Adams: pja_ad@yahoo.co.uk

## SEPTEMBER 2016

**5 – SOUTH YORKSHIRE BRANCH**
Neurological Update by Jean Mooney. 9.15-9.45 am Registration/Refreshments, 10am-4pm Educational Session. Email: greensidepod@hotmail.co.uk Contact no: 01226 388622/384135

**6 – EAST SUSSEX BRANCH**
Conflict Resolution/ Personal Safety (with regards to lone working). Speaker Jenny Lloyd-Lyons, East Sussex Healthcare NHS Trust. Held at Dept. of Podiatry, University of Brighton Leaf Hospital, St Anne's Road, Eastbourne, unless otherwise stated. Meetings start at 7.15pm, doors locked by 7.35pm. For further details please contact Lesley Baker: labaker@btopenworld.com or 01323 764393.

**7 – GREATER MANCHESTER PRIVATE PRACTICE NETWORK**
Paddings and Strappings Evening: Hands on Practical Workshop with Cuxson Gerrard. Venue: Manchester Maccabi Community & Sports Club, Brooklands, Bury Old Road, Prestwich, M25 0EG at 7.30pm. Contact: Lindsey 07575285815. Booking Essential. Early bird price available. To book log onto www.manchesterpodppn.eventbrite.co.uk

**13 – KINGSTON & SOUTH EAST BRANCH**
ABPI Dopplers and New Dopplex Ability by Andrew Yuille Huntleigh Diagnostics. Time: 8pm. Venue: Post Graduate Medical Centre, St Helier Hospital, Carshalton, SM5 1AA. Email: secretary@kslbranch.co.uk

**21 – BUCKINGHAMSHIRE BRANCH**
'Soft tissue Pathology, Imaging and Intervention in the foot and ankle with Lyndon Jones' (Evening Branch CPD: 7 30 - 9 pm) at the Duke of Edinburgh Education Block, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL. Contact details for the above courses and CPD events: Paul Adams: pja_ad@yahoo.co.uk

# CLASSIFIED ADVERTISEMENTS

## SITUATIONS VACANT

**RINGWOOD, NEW FOREST**
Podiatrist / Chiropodist Vacancy. Experienced or newly qualified podiatrist required as soon as possible for Employed position. Salary + Bonus, Full Time. Keen interest in Biomechanics necessary. Mentoring and CPD available. Busy team in a multi-disciplinary re-furbished Health Clinic. Official Chiropractors/Osteopaths for AFC Bournemouth premiership football team.
**For further information or to apply please contact admin@bodyconsultancy,com or email CV with covering letter.**

**SOUTH EAST LONDON/KENT**
Thriving practice looking for a reliable, self-motivated, HCPC registered podiatrist to take on 1 or 2 days per week. Wednesday and/or Fridays available immediately, joining a friendly well-organised team. CVs please to: PodiatryVacancyCV@gmail.com

**SURREY** Podiatrist required for friendly, busy expanding practice, 3 days per week with potential to extend to 5 days. Would suit newly qualified individual, mentorship available. Own transport is essential for clinics in neighbouring towns. Please email CVs to; surrey.feet@gmail.com

**EAST MIDLANDS, MELTON MOWBRAY** Associate podiatrist required for expanding practice to work on a part time fee share basis. Candidates must have excellent interpersonal skills and an enthusiasm to learn new skills. All enquiries to Sue and Katy at info@meltonfootclinic.co.uk

**LAUNCESTON CORNWALL** Podiatrist required. Candidates must have excellent clinical and interpersonal skills and be reliable and flexible. Mentoring and support will be provided. Domiciliary work will be required. Apply in writing with a short CV to: - Siobhan McCutcheon clinic@marketstreetclinic.co.uk 01566 777600

**SHEFFIELD** Established Podiatry Practice requires reliable full/Part-time Podiatrists for employed position. Please send your CV francisrena@hotmail.com or call 07866716051.

**HERTFORDSHIRE New Start Up Opportunity** Fee Share – Goff's Oak Well-equipped clinic in multidisciplinary modern premises. Excellent potential from affluent patients in adjacent 10,000 GP practice. (http://www.cuffleyvillagesurgery.co.uk/). 3 days per week. Extensive parking, disabled toilet, elevator.
**Call Now: 07775877911 or email with your CV. james.cameron@pharmastrat.co.uk**

**NOTTINGHAM CITY CENTRE.** Are you ready to put someone's feet first? Feet First Chiropody Ltd. are seeking to appoint an excellent HCPC registered to join our brilliant podiatry team in our extremely busy private practice. The best candidate must be reliable and flexible who will continue to produce our high class foot treatments with outstanding customer care. To begin with, the position will be part time with the flexibility to cover holidays and sickness. As a growing business we would also like to expand into the domiciliary market. To apply, please email a covering letter with your CV FAO Recruitment to feetfirstchiropody@fsmail.net

**DERBY** a well-established practice in Derby seeks a podiatrist to work 2 mornings a week, plus sickness/holiday cover. Must be HCPC registered, DBS checked and have own transport. Please send a CV and a covering letter to bgunchala@yahoo.com

**GORSEINON, SWANSEA (SOUTH WALES)**

HCPC registered Podiatrist required to join our multidisciplinary team. Self employed, part time position on a fee sharing basis at a busy town centre clinic, alongside 4 podiatrists. Initially domiciliary work, with scope to expand to clinical work.

**To apply please forward your C.V to emma.gowman@crossroadsclinic.co.uk**

**EAST MIDLANDS** We are a leading multi-disciplinary podiatry practice in the East Midlands and are looking for a degree qualified, HCPC registered, highly skilled podiatrist to join our team. We are a well-established business with loyal patient database and increasing number of new patients via recommendation and referral. This is a part time position initially with flexible hours to be agreed. Initially salaried with possibility for self-employment in the future. Please show your interest by sending us your contact details/CV via trishgrantham@hotmail.co.uk

**HESWALL, WIRRAL** Experienced Podiatrist required for busy practice (across two sites). Starting with one or two days, rising to further days. The successful applicant must be prepared to work early mornings and/or evenings. Excellent fee sharing remuneration. For initial chat telephone 0151-342-9665.

**COULSDON, SURREY CR5 2NF**
Skilled, part-time HCPC registered podiatrist required for two days per week. At least one year's experience preferred. Salary within band 6 range. Alternatively

**To place an advert**
**Email classifieds@scpod.org or Tel: 020 7234 8639**
Advertisements must be posted to the Society address for the attention of Tina Davies or emailed to classifieds@scpod.org, along with credit card details to cover the appropriate payment. Emails are only accepted if payment is received before closing date. Adverts are not accepted over the phone and are to be paid at the time of placing the advert.

**PRICING:**
Members up to 40 words: £35. Each additional 10 words: £5Non members up to 40 words: £60. Each additional 10 words: £10
Boxed adverts: £60 members and £80 non members. (Wording limited to 50 words.)
All prices inclusive of VAT.
Payment to be made via credit/debit card.
All adverts will be posted on our website within 2 working days.

**Box number replies** cost £2.50. Confidentiality will be maintained. Replies to c/o the Society of Chiropodists and Podiatrists, Quartz House, 207 Providence Square, Mill Street, London SE1 2EW

**ENTRIES FOR JUNE MUST BE RECEIVED BY MIDDAY 29 APRIL**

shared fees considered. Friendly, supportive and busy practice. For further information phone 020 8660 0349. Please email CV to thefoothealthcentre@gmail.com

**LONDON, CHELTENHAM AND ALDERLEY EDGE, MANCHESTER** Margaret Dabbs London is the industry leader in medical foot care providing podiatry treatments in its own clinics undertaken by highly skilled and well trained podiatrists backed up by top quality equipment and administrative assistants. Due to rapid expansion, Margaret Dabbs London is searching for both full and part time Podiatrists to join the dynamic and dedicated team to work at one of the Margaret Dabbs clinics. If you are a fully qualified Podiatrist with clinical experience (with full HCPC registration) and are interested in career progression in an exciting and dynamic business at one of these clinics then we want to hear from you. In return you will be rewarded with job satisfaction, a top salary (in the range of £30-45k) and outstanding training and career-development. Please send a copy of your CV to tamara.iglesias@margaretdabbs.co.uk

**TYNE & WEAR** Enthusiastic Podiatrists sought to join our expanding business. The successful applicants will require good clinical and inter-personal skills, to be part of a team and with the ability to work independently when required. Part and full time positions available.

**CVs Please to:**
danielle.clark7@nhs.net
**by 15th May.**

**WIRRAL, MERSEYSIDE** Podiatrist required on a part-time, fee-sharing basis, initially for up to 2 half-days per week plus one Saturday morning per month. The applicant must be reliable, friendly, patient-focused and have excellent clinical skills. Experience in all aspects of Podiatry is essential. Some domiciliary work may be necessary and so own transport is required. Forward CV to clairej310@outlook.com

**CAMBERLEY, SURREY** Long established private practice seeks a skilled HCPC registered Podiatrist for one/two days per week including Saturday mornings to cover existing caseload. Days, hours and terms negotiable. For further information telephone 01276 682980. Please email CV to camberleyclinic@gmail.com

**NORTH COAST SCOTLAND** Expanding Thurso + Wick practices require HCPC reg. Podiatrist 4 days a week to cover a varied caseload within clinic and DOM environment. Experience not required but a confident, reliable, self-motivated, car owner is. Fee sharing basis, with additional annual bonus towards CPD + skill expansion. Contact Faye 01847 893727 or CV + covering letter to fayeswilson@gmail.com

**EAST SUSSEX, HAILSHAM** A well established private practice seeks a part time HCPC registered Podiatrist on a fee sharing basis. Excellent interpersonal and clinical skills essential. Please email CV to russellharrisonpodiatry@gmail.com

## PRACTICES FOR SALE

**EAST SUSSEX COASTAL TOWN** Well established thriving part time practice. Clinic and domiciliary patient list for sale. Some equipment also available. Owner retiring. Genuine enquiries only please. Email: podos1@outlook.com

**LEEDS CITY CENTRE** 12-year chiropody goodwill practice for sale, based in the heart of Leeds city centre. Potential for growth and expansion. Plus room available to rent at a very reasonable rate. Contact 07980064092.

**LEICESTERSHIRE** Excellent investment opportunity. A long established and highly reputable practice for sale which includes a state of the art Gait Scanning system. 3 clinics with flexible and low rate room rental options. Turnover 90k plus regular patient base with excellent goodwill. Enquires to info@feetnesspodiatry.com

**HARPENDEN, HERTFORDSHIRE** Podiatry practice in multi-disciplinary clinic with reception in high street of prestigious Harpenden town. Goodwill and equipment circa £95,000. Contact: info@podiatry-chiropody.co.uk or mobile: 077911 04311.

**WISHAW NORTH LANARKSHIRE** Two day full clinic with potential to expand. Contact Liz on tel: 07817631557.

**CLAYHALL, ILFORD, ESSEX** Twenty year plus, well established and respected practice for sale. Large and still expanding computerised patient base. Four days a week plus domiciliary, genuine potential to expand. Situated on ground floor, self-contained purpose built surgery incorporating two equipped treatment rooms, one of which is currently rented full time to a chiropractor/physio. Sale includes goodwill, equipment, stock, and secure lease. For confidentiality agreement and further details please email annepod@live.co.uk

**EAST DEVON** Excellent opportunity to purchase well established, rapidly expanding, part time practice. Moved to newly refurbished premises last year in prime town centre location. Reasonable rent with potential for long lease. 5 miles from Lyme Regis and beautiful coastline. Sale due to owners' R.S.I. Details: sheila_holland@hotmail.com

**BRISTOL AND SURROUNDING AREA** Well established, thriving domiciliary practice for sale. 500+ existing patients, majority of which being regular repeat customers. All enquiries or for more information please contact Olivia Page on 07771907234 or page_olivia@yahoo.co.uk

**TOOTING BEC LONDON** A unique opportunity to take over a well-established practice in London for an ambitious podiatrist. Running for over 70 years on a superb high street location, leasehold premises also comes with two flats and a workshop which are all sub-let. Currently full time practice including domiciliary and staff, large patient base with also genuine potential to expand. Sale due to relocation and career break. Sale to include all equipment and goodwill. For more details please contact Shalla on 07985221099 or shallamzaman@gmail.com

## ARTICLES FOR SALE

**PLINTH 2000 TREATMENT** couch with operator's chair finished in elephant grey £350. Mayo table £50. Work station £25. All available from end of May. Photos available defeat1@hotmail.co.uk or phone 01245 441745 after 6.30pm. Buyer must collect (Malden, Essex).

**LUNULA LASER MACHINE.** £12,000 o.n.o. Purchased October 2014. Excellent Condition. Please call on 0800 907 0093 or email info@beauchampfootcare.com (SW3, Knightsbridge. London).

**CAR REG PLATE** TOE 916 no year prefix – word prominent – impending emigration forces sale – £995 o.n.o – contact pedimedics@hotmail.com

**PODIATECH** Twinlab II Thermoforming system complete with silicone vacuum casting bags and stand - £500 ono - all in good working order. Range of insoles and additions included to get you started. Contact Steve 07973308931 can supply pictures (Epsom, Surrey).

## REPAIRS AND ORTHOTICS





## SPECIALISED SERVICES NOTICE!

**Specialised services has now been discontinued.**

**As of January 2016 we will have in its place a service for companies that provide Repairs for medical equipment.**

**Get the attention your advert needs by placing a 1/8 page advert in your own design OR we will be happy to design the advert for you. The cost of advertising in the 'Repairs' section will be £100 inc VAT.**

**Please contact Tina Davies for more information;**
**Contact number: 0207 234 8639**
**Email: td@scpod.org**

## CLASSIFIEDS

The Classified Ads section is the ideal place to advertise if you are selling your business, looking for a new member of staff for your private practice or have equipment for sale.

Contact Tina Davies on 020 7234 8639 for more information.

PODIATRYNOW

# RECRUITMENT

**Contact:**
Alex Montieth
**Tel:**
020 7880 7613
**Email:**
alex.monteith@
redactive.co.uk

**Booking deadline for JUNE is midday, 29 APRIL 2016**
**Despatch date for JUNE is 20 MAY 2016**

## RECRUITMENT ADVERTISING RATES

| Size | Dimensions (mm) | Rate |
|---|---|---|
| Full page | 264(h) x186(w) | £4,700 |
| Half page vertical | 264(h) x 93(w) | £2,350 |
| Half page horizontal | 132(h) x 186(w) | £2,350 |
| Quarter page | 132(h) x 93(w) | £1,175 |

## 2016 DEADLINES

| Month | Booking | Mailing |
|---|---|---|
| June | 29 April | 20 May |
| July | 3 June | 20 June |
| August | 24 June | 20 July |

# CANCER: WATCH YOUR STEP!

## MAY 2016

### WORLD FOOT HEALTH AWARENESS MONTH

International Federation of Podiatrists
Fédération Internationale des Podologues

United Kingdom | The Society of Chiropodists and Podiatrists (SOCAP)
+(44) 854 450 3720 | www.feetforlife.org or www.scpod.org

FIP-IFP supported by:

Clarks
www.clarks.com

Spenco Medical
www.spenco.com

Tekscan
www.tekscan.com

# daniPro
INFUSED NAIL POLISH


**£6.95**
**PER BOTTLE**
**(RRP £11.95)**


## Introducing DaniPro

### The only doctor formulated nail polish infused with Undecylenic Acid

▪ Safe ▪ Organic ▪ 100% Natural

### Bringing together the arts of beauty and science...

daniPro is a premium blend, rich, luxurious, and chip resistant nail polish. It is Toxin FREE and infused with Undecylenic Acid.

daniPro is different from other nail polishes. It contains Undecylenic Acid and is completely free of the damaging chemicals found in so many of todays most popular brands, including formaldehyde, formaldehyde resin, toluene or DBP, daniPro has also never been tested on animals. This toxin free polish is available in an assortment of colours for the perfect manicure or pedicure.

### A safe and proven formulation

- No formaldehyde
- No formaldehyde resin
- No DBP
- No toluene
- No animal testing
- Smooth application
- Fast drying formula
- Unique shaker ball ensures consistency


canonbury
HEALTHCARE
WITH YOU EVERY STEP

**01280 706661 | canonbury.com**

Trade price of £6.95 excludes VAT, RRP of £11.95 is inclusive of VAT.