Seek and Ye Shall Find

Here are some tips to avoiding pitfalls in the podiatric skin examination.

By Bryan C. Markinson, DPM

The main, but not exclusive focus in this issue of Podiatric Dermatology is the initial exam of a patient where the chief complaint does not involve the dermatologic system. The key thing to keep in mind here is that self-review of our own unique ways of practice may often turn up ways to improve. Although the first priority is better patient care, it is undeniable that such self-reflection may impact on billing and risk management issues. This goes beyond counting bullets of documentation or judging levels of complexity. More to the point, it is more than simply about whether or not we do things. It is whether how we report them is meaningful or not.

Documentation Templates

Exam note templates help with documentation requirements. In my typically careful surveillance for pigmented lesions, I noted the sentence "No pigmented lesions noted" in the dermatology section of my "Normal Examination" template. When I wrote the original template, this notation gave me comfort that if anything developed after the visit, this note would be proof that it started after my examination. After reviewing too many cases of alleged delayed diagnosis, I can tell you that the best documented notes are often called into question and can result in poor defense outcomes. To be sure, this does not compare to the incidence of unfavorable defense outcomes due to poor documentation.

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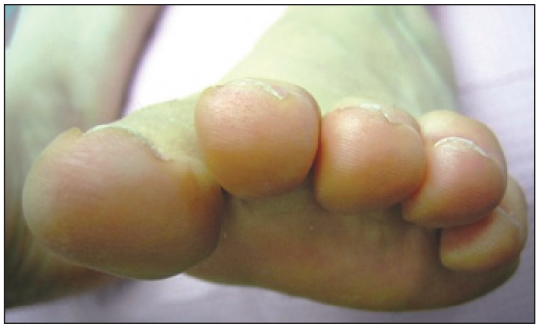

Figure 1: This may be the typical way the foot is first viewed while examining this patient for ankle pain. Notice all the area of the skin which is not visible.

An Actual Case

Recently, I reviewed a case where DPM # 1 noted a lesion on the "right heel" as an incidental finding during a diabetic foot exam. DPM # 1 noted in the record that the lesion was debrided and a foreign body removed from it. A repeat visit soon after yielded the chart notation that the wound was "healed." The patient never returned.

Some eight months later, the patient writes a note to the treating podiatrist #2 (she changed her HMO) stating that the original spot, which was the size of a "pinpoint" when she saw DPM #1, was getting noticeably larger. She even specifically requested that a biopsy be performed. None was. She was eventually diagnosed with melanoma, and brought suit against both podiatrists. In the deposition of DPM#1, the chart notation "right heel" proved to be meaningless, as it became clear that although "right heel" certainly was enough for billing purposes, it left him unable to state exactly where the lesion was (even if his recollection was total) or to refute that the lesion diagnosed as melanoma was not the same one.

I proposed that the case was defensible for DPM #1 due to the patient's own description of the lesion being pin-point in size at the time of the evaluation. The outcome is not important, but be sure that a more accurate description of the location of the lesion, and some reference to its size and color in the chart would have been better to have. But that is only in hindsight....I believe 90 percent of us would have similar notes in the same circumstances, which is entirely to the point of this essay.

After critical review of my own template, I realized that the notation "no pigmented lesions noted" also means that I actually looked for pigmented lesions during the visit. This notation was appearing

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Ye Shall Find...

in many notes that I had written where the chief complaint may have been an acute nail infection, a broken toe, or some other such problem where I could not guarantee to myself, in reflection, that the notation "no pigmented lesions noted" was at all accurate, and therefore at all meaningful.

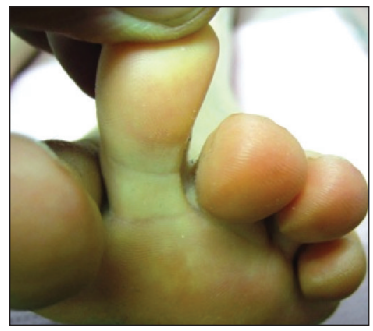

Figure 2: Note that extension of the digit is required to actually view the plantar surface of the toe in its entirety.

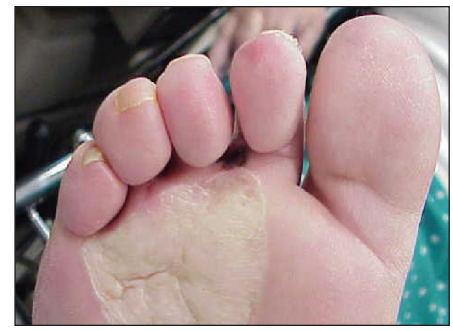

Figure 2A: Note pigmented lesion abutting prior skin graft in sulcus between toes 2 and 3, probably present for many months at time when patient was seen regularly by a podiatrist for nail care.

My goal is not to imply that use of templates may unwittingly result in fraudulent notes, but to advise that they should be used as a reminder to actually do what they state, or delete portions of them from the particular note in question. Will a teenager and his or her parent remember if you tested the deep tendon reflexes if they show up two months later at a neurologist with progressive lower extremity neuromuscular symptoms? Maybe.

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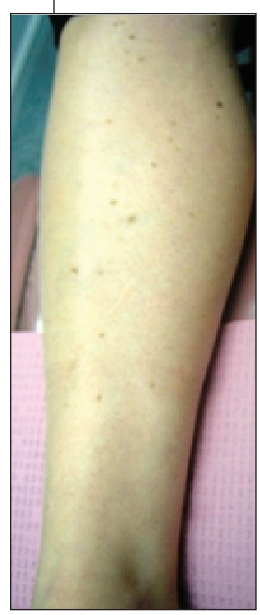
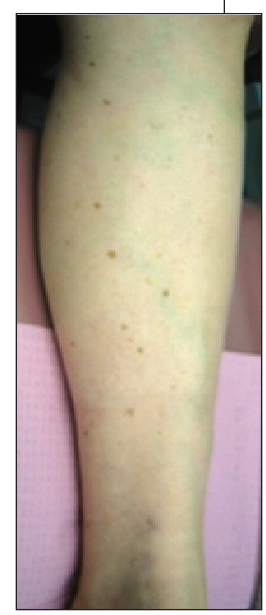
Skin observation, however, often is done in silence while you are talking about the procedures for permanent partial nail surgery, or explaining the mechanics of plantar fasciitis. If all is normal, you may not even comment about it, yet have a few lines written in the final notes of the visit to cover your "body system" bullet requirement. Hopefully, if the chief complaint involves the skin, then both patient and physician are focused on a more detailed evaluation.

Potential Problems

Let's review some potential problems in the "cursory" skin exam that most of us probably do in the majority of our daily practice, especially when the chief concern does not involve skin and/or nails.

Let us assume that a 27 year old female lacrosse player is referred to you for the first time by a family practitioner for evaluation and treatment of a chronic tibial sesamoiditis of the right foot. The patient is being referred because the family practitioner believes orthotics are indicated and that you would be best able to prescribe and dispense the most efficacious device. The patient fills in the intake forms which are reviewed by you either in a consult room or exam room.





Figures 3 and 4: Views of the medial right (3) and left (4) legs

Eventually, the patient is in the examination chair, probably with the lower extremities from the knee down visible. You begin your examination by palpating the pulses, feeling the skin temperature, and perhaps spreading the toes apart to observe the toe webs (or not). You may make certain assumptions about the patient being that she is an athlete, such as that her muscle power is probably normal in all groups, that her reflexes are intact, etc. You may even accept at face value that prior exam findings, if available, from the referring doctor are accurate and repeating the same parts of the exam may not be required.

I do not think we would be entirely honest if we all did not accept that this is possible in the busy day-to-day practice of podiatric medicine. You palpate the tibial sesamoid, review x-rays, do a weight-bearing exam and perhaps a gait exam, and cast the patient for orthotics. Two weeks later, on a very busy day, you dispense the devices by seeing how they fit on the foot with socks on, put them in her athletic shoes, discuss break-in instructions and out the door she goes.

Four months later, the patient shows up in the emergency room with an oozing lesion on the medial aspect of the fifth toe left foot. She tells the ER doctor that she has had a mole there for many years which has gotten darker and elevated over the past year. Her dermatologist had recommended a biopsy that she never got around to because of lacrosse tournaments. A few months later requests are sent for the dermatologist's and your chart notes.

Is it possible that you missed it? You review your notes. Here is all they say about the skin

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exam and/or the fifth toe of either foot, which is in part from a template:

Dermatologic: The skin is supple and well-hydrated. There are no rashes noted. The toe webs are clear. There are no signs of ulceration or impending ulceration. The toenails are clear for the most part, but the right hallux nail is somewhat dystrophic, probably from repetitive subtle trauma. The fifth toenails bilaterally are thickened, most proba-

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bly due to trauma as the toes are in varus rotation.

Orthopedic: The patient has semi-rigid high arched feet bilaterally. There are no gross deformities. Joint range of motion throughout the foot is within normal limits. Weight bearing examination does not reveal excessive pronation or other signs of hypermobility. There are no keratotic lesions. The fifth toes are underlapping the fourth bilaterally, which has not been a problem for the patient. There are no soft tissue masses or palpable nodules.

You begin to think to yourself: "Did I actually examine the toe webs? Did I just do a quick skin exam in view of the complaint? Did I look at the left foot at all after I palpated the pulses? I don't remember seeing a mole or other pigmented lesion. I know that the patient didn't tell me anything about it. If the toe is underlapping and I didn't actually open the toe web, I could have missed it. My chart states that the toe webs are clear. Now I am not sure..." Continuing, one may start to question where on the foot and/or leg was the skin well hydrated, or absent of any rashes. So, on the surface, what appears as a well documented note, certainly from a reimbursement standpoint, may not be so well documented as to the actual findings or lack thereof.

If this or a similar scenario (not necessarily involving such a serious a diagnosis) is totally foreign to you, then Bravo! If we are honest, then we must admit that for most of us mortals, this is a real life event that can and does happen. This is just one example. There are certainly parallels in any other body system impacting on the foot and leg. For example, that beautiful Charcot reduction you just performed...is it not possible in the post-operative period that you may have examined the patient a few times without taking off the shoes and socks of the other foot? Did you ever treat a patient for a diabetic ulcer and realize that over the course of a few months you do not have any statement as to the quality of the pulses, as you concentrate on wound size, depth, presence of granulation, and the status of the glycosylated hemoglobin? Are these failures to practice good medicine, or incidental to the practice of good medicine? I am sure that those of you who see 50 or more patients a day have one answer, and those who can't seem to handle more than twenty have another. However, this is about how the documented performance of a cursory skin exam or any other system can indeed end up being meaningless.

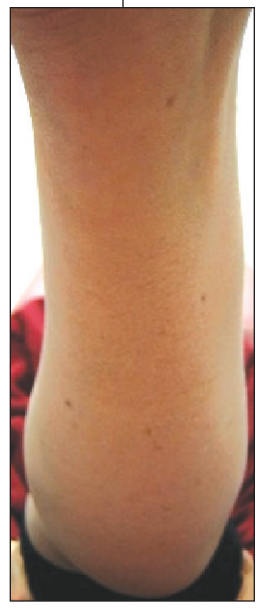
Did you ever treat a patient for a diabetic ulcer and realize that over the course of a few months you do not have any statement as to the quality of the pulses, as you concentrate on wound size, depth, presence of granulation, and the status of the glycosylated hemoglobin?

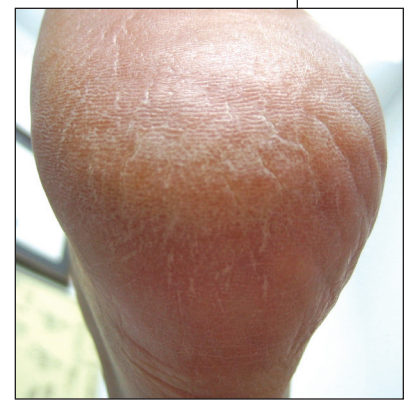
Cursory Skin Exam

So, then, what constitutes a "cursory" podiatric skin examination that should result in at least the viewing of all of the required skin, and to the furthest extent possible, the least possibility of missing something noteworthy?

Generally, the podiatric patient spends most of the time during the encounter in the treatment chair, sitting upright with the legs extended straight out. The entire posterior leg and heel is usually not viewed. That is a lot of surface area to leave out if you are doing any sort of exam of the skin. Additionally, your position most often is sitting on a treatment stool, somewhat hunched over the feet, which mostly are in relaxed plantarflexion. All of the following photos are of the same patient (Figure 1). Notice how much is not visible in this typical patient presentation. Let us assume that the patient's chief concern is ankle pain. Note that the entire plantar surface is not seen. Note the slight plantarflexion of the toes, leaving the plantar toes completely obscured from view.

Figure 2 demonstrates how it is actually necessary to fully extend the digits to get a total view of the plantar aspect of a toe. The same is obviously true for the plantar aspect of the feet. Figure 2A shows a partial plantar view of a patient of mine on whom I performed a wide excision of a melanoma with a skin graft. She was a resident of a nursing home, and in her chart the history of this diagnosis and surgery was prominent. After being discharged from my care after about one year, she had regular podiatry care in the nursing home for her toenails. The podia-





Figures 5 and 6: A full posterior view of the leg and heel can only be accomplished by lifting the leg or placing the patient prone on the treatment chair/table.

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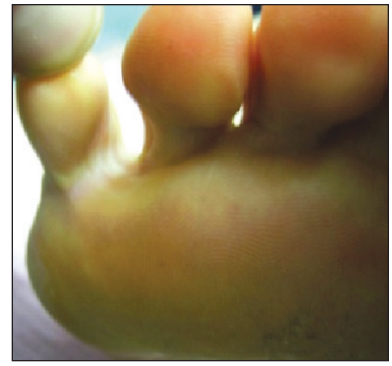
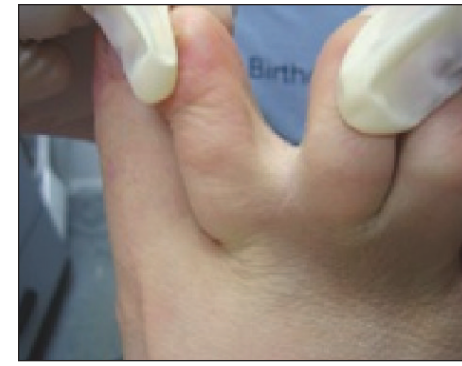
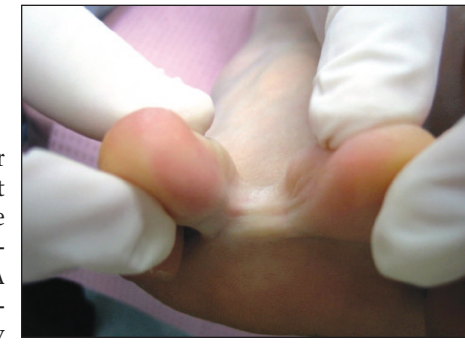
trist saw her at least five times in the year after discharge, and certainly within two months of this photo. She was also seen by physicians, nursing staff, and multiple aids.

The lesion became evident only when blood was noted on her socks. Biopsy of the lesion revealed it to be a new ulcerated primary melanoma. Just imagine that in a typical nail care situation, the DPM would come up to bedside, palpate pulses, and trim or debride the nails looking straight down on the foot, which is usually slightly plantarflexed. Can it be possible, even understandable, that he could have missed this lesion? The answer is yes, certainly if she had no history. One would strain to defend this in light of her history, but that is not the point. The point is that any notation of a skin exam in her chart by the DPM in the nursing home, and any other professional who cared for her, would be meaningless. Note in the photo the black lesion in the sulcus area just abutting the outer margin of the graft. Upon questioning by the family, the D.P.M. could only state for sure that he was not sure if he ever looked, but was pretty sure he would have done something had he noted it. However, all the bullets for routine foot care were well documented. A very easy-to-do cursory skin exam by anyone would have picked up this lesion.







Figures 7, 8 and 9: All demonstrate typical toe web exams. While they all have limitations, it seems that the exam shown in figure 9 is most revealing.

Now let's take a look at the medial aspect of the right and left legs, shown respectively in Figures 3 and 4. Note

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the multiple moles on both legs. Also, note that the lateral aspects of the legs are completely out of view from this vantageless point. With the patient's legs unexposed, or not observed, and in the absence of such lesions on the feet, my notation "no pigmented lesions noted" would be rendered meaningless. This is because the notation reveals nothing about the breadth of the skin examination. What about the posterior leg and heel, resting on the treatment chair completely out of view for most of a typical visit? Figures 5 and 6 show how the legs must be raised or the patient must be prone to properly view the posterior leg and heel. I am sure that I have not done this many times while indicating notes that speak of "normal hydration" or "no palpable nodules," etc. In this particular case shown, while the patient's dorsal foot skin and leg skin is of normal hydration, there is marked xerosis of the heel.

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The toe webs spaces are of equal concern. Unless they are spread open, and observed from both the dorsal aspect and plantar aspect, while paying attention to the medial and lateral sides, you really cannot make a full assessment of a toe web (Figures 7, 8 and 9). This demonstrates how positional changes of the examiner are also required to get best views of the skin surfaces in toe webs.

The same principles apply when examining the medial and lateral aspects of the feet. So, a complete cursory exam of the skin of the lower legs and feet can be thorough in part, but in fact incomplete when the chief concern is not dermatological. It takes literally a few seconds to do this exam properly, and I guarantee that in the elderly population alone, just deciding to examine the skin between the malleoli and the tibial tubercle on all surfaces during every visit will generate many lesions suspicious enough for biopsy or at least referral for further evaluation.

All non-dermatologists in medicine are primary skin care providers in their area of expertise. We all need to just look....and we will find. ■

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