



BY JARROD SHAPIRO, DPM

What I Wish Primary Care Doctors Knew

PCPs should leave diagnosis of foot and ankle problems to DPMs.

Practice Perfect is a continuing every-issue column in which Dr. Shapiro offers his unique personal perspective on the ins and outs of running a podiatric practice

For any podiatrist in practice, there are any number of challenges to patient care. Unfortunately, sometimes these challenges are generated by the very primary care colleagues who refer patients to us. If there are a few topics our medical partners should be aware of, they would be the following:

Stop Ordering Non-Weight-Bearing Radiographs

This one occurs daily. We receive a new consultation for a patient who saw their PCP and radiographs were ordered. Clearly, it's good forethought that the doctor is trying to obtain imaging prior to the patient seeing the specialist. However, non-weight-bearing radiographs are only helpful for some trauma and a few other things. We can't gather anything mechanical from these images. And, in fact, for 5th metatarsal fractures, you can't see the 5th metatarsal on a non-weight bearing radiograph.

It's also helpful to stress the Lisfranc joint for these injuries (especially the subtle ones), and weight-bearing can help reveal subtle displacements. Any radiographs ordered outside of a hospital setting should be weight-bearing.

Actually, stop ordering foot and ankle radiographs at all and let the podiatrists do them.

We often must re-do radiographs because the images obtained are not useful. As an example, for patients with first metatarsophalangeal disorders, dorsoplantar, lateral, and sesamoid axial radiographs are best. The oblique views are useless for this pathology. Orthogo-



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nal views are much more helpful. This is similarly the case with flatfoot conditions, in which the DP, lateral, and calcaneal axial views are best.

Of course, if you're considering a tarsal coalition, then add in a medial oblique view. And if you're considering an accessory navicular problem, then a lateral oblique radiograph of the foot is necessary. And then, if you're examining the effect of a flatfoot condition on the ankle, then ankle images are needed. And in other cases, full leg imaging may be in order. You know what? This is too complicated for our referring PCPs to worry about. Referring docs would be best just not ordering the imaging at all and let the podiatrists determine what imaging is needed.

Stop Telling Patients They Have a Heel Spur

This may be the most frustrating one. We regularly have patients with

heel pain referred for "heel spurs" or the patient presents stating, "My doctor told me I have a spur." It's well known that the plantar calcaneal spur is not the cause of the diagnosis commonly referred to as "plantar fasciitis", or plantar fasciosis if you want to be more accurate. The spur isn't generally the problem unless it's fractured, facing plantar, or involved with a rheumatologic disorder.

We spend more time than necessary debunking this myth. While it's easy to point to this abnormality and blame it for your troubles, this is a little more subtle problem than simply "there's a spur, so it must hurt."

Don't Order MRIs in the Hospital for Osteomyelitis

This may be the most damaging of practices because MRI of the foot for the diagnosis of osteomyelitis is unnecessary.

Continued on page 30

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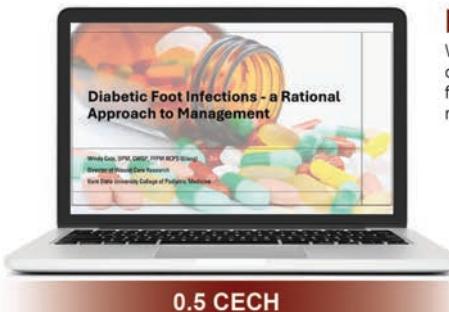
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Featured Lecture



Windy Cole, DPM, CWSP,
FFPM RCPS (Glasg)
Director of Wound Care Research
Kent State University College
of Podiatric Medicine
Independence, OH

Diabetic Foot Infections - The Problem and a Rational Approach to Management



0.5 CECH

In this Lecture...

Windy Cole, DPM, CWSP, FFPMM RCPS (Glasg) discusses evidence-based practices for treating diabetic foot infections including addressing rising antimicrobial resistance.

Scan to go
to the lecture



Primary Care Doctors (from page 29)

sary in almost (but not quite) all of the cases of hospital-based bone infections.

Bottom Line: T2-weighted MRI images that show only increased signal intensity in the bone (AKA bone marrow edema) are nonspecific and do not diagnose this disorder. It requires a properly read T1 image using specific criteria to increase the post-test probability of osteomyelitis. If Charcot is present, it's basically impossible to know for certain. If there's no wound, then it's an almost 100% probability that it is NOT osteomyelitis. Biopsy is still superior. Don't waste time and money. Consult podiatry in the hospital first and let them decide. This is why a team approach is best.

It's Not Arthritis If You Can't Figure Out the Diagnosis

Commonly, patients with foot pain present to me stating they have "arthritis." "What joint is the arthritis in?" we ask. "I don't know. 'All of them,' my doctor told me," says the patient. "Do you have rheumatoid arthritis?" we ask. "No," affirms the patient.

After the physical exam, we review radiographs together and lo and behold, there's no arthritis to be found anywhere!

Osteoarthritis has very specific radiographic findings: osteophytes, asymmetrical joint space narrowing, eburnation, intra-articular osseous bodies,

A calculation from the Clinical and Research Information on Drug-Induced Liver Injury Database from the National Library of Medicine that found clinically apparent liver injury from oral terbinafine was 1 case in 50,000-120,000 treatments.

and often cystic changes. If these aren't present, then it's something else. It's okay, primary care docs, if you can't figure out the diagnosis. That's what podiatrists are here for!

Terbinafine Is NOT Dangerous

Oral treatment of onychomycosis with terbinafine is the most successful method. Period. It's hands down better than topical. You might wish this weren't the case. But it is. Because several other oral antifungal medications have a large number of drug interactions and can affect the liver significantly, many primary care doctors think terbinafine will also. This isn't true. A calculation from the Clinical and Research Information on Drug-Induced Liver Injury Database from the National Library of Medicine that found clinically apparent liver injury from oral terbinafine was 1 case in 50,000-120,000 treatments.¹ Terbinafine is an allylamine antifungal with a different mechanism of action

and drug profile from the azoles. It interacts much less and is safe to use with those with normal liver function. Don't scare patients away from this. In fact, don't bother starting patients on this and send them to podiatry so we can institute a more comprehensive plan to treat this issue.

In today's modern medicine community, it is too complicated to be an expert in everything, so primary care doctors and hospitalists should not feel the pressure to be foot and ankle experts too. Leave that up to podiatry; we're happy to help and love being part of the healthcare team. PM

Reference

¹ Mikailov A, Cohen J, Joyce C, Mo-staghimi A. Cost-effectiveness of confirmatory testing before treatment of onychomycosis. JAMA Dermatol. 2016 Mar;152(3):276-81.

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