BY JARROD SHAPIRO, DPM

Why Podiatrists Should Know Medicine

It's a necessary part of being a physician.

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.

Should all podiatrists know medicine? In reality, the answer to this question is a simple 'yes.' The reason it's so simple is that it is in our best interests as physicians and also incredibly helpful to our patients.

For example: it's not uncommon to see patients for bilateral plantar foot pain (sometimes bilateral heel pain) who present with complaints that don't sound like typical plantar fasciitis. They've been treated by several other physicians, often podiatrists, with a variety of ways, none of which helped the patients. After some investigation, it turns out to be lumbosacral radiculopathy. Understanding and finding this diagnosis requires a more global view of the body. Obviously, the treatment for this problem is highly different from that of plantar fasciitis.

Since we podiatrists like to call ourselves "podiatric physicians", we need to emphasize a bit more the "physician" part of this. It's a simple talk the talk, walk the walk argument. We need to be able to speak the same language and function similarly to our colleagues in the medical community. This requires training that is similar (not the same, mind you, just similar) to MDs/DOs.

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Additionally, it allows us to simply provide better care. How many medications are your diabetic patients currently taking? Do you understand how these various medications might interact with something you prescribe? Do you know what terbinafine will do to a patient's anticoagulation status if the patient is on warfarin? Do you know how to identify and treat a duodenal ulcer that occurs as a result of the anti-inflammatory you've prescribed?

A while back, there was a young female patient with a bilateral non-blanching purpuric rash on the arch of her feet. Anyone focusing entirely on her feet would have called this tinea pedis or dermatitis, prescribed a cream and been done with it. However, upon further questioning, it turns out that her father had a CVA at 35-years-old. This raised an index of suspicion, so a battery of autoimmune tests were ordered, including a hypercoagulable panel, and lo and behold, she had a factor V Leiden deficiency. Upon learning this, she was referred back to the primary care physician after a phone conference. Hopefully, the patient will not have to suffer the same fate as her father. This demonstrates the importance of the podiatric visit and the opportunities to help our patients if we keep a more global view.

It's entirely possible that your gout patient could suffer from gout as a result of cancer. The increased metabolic

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state and tissue breakdown may lead to hyperuricemia and subsequent gouty arthropathy. Are you aware of this relationship? There was never a hematology class or rotation while in training. This is learned while in practice. More commonly, podiatrists need to understand the role of antihypertensive medications and renal disease in the etiology of gout. How can a podiatrist recommend a reasonable course of action if he doesn't understand that thiazide diuretics alter the excretion of uric acid from the kidney?

This list goes on and on: psychological pathology in many of our patients, cardiac disease and various endocrinology problems. Is your idiopathic neuropathy patient suffering from occult undiagnosed diabetes or cervical myopathy? Does bilateral hand and foot numbness and paresthesias raise your suspicion for another diagnosis? Do you ask about hand numbness, or is that too far above the ankle to matter? Are you able to perform a full body neurological examination when necessary, or do you just check protective sensation? There are so many new medications our patients take. Do you stay up-to-date?

One argument often made regarding orthopedists: Someone once said, "Orthopedists don't know everything; they consult other doctors and focus on the bone and joint diseases, and they are still doctors." This may be true, but we podiatrists have a different charter than orthopedists. We are not only bone and joint doctors, but also dermatologists, neurologists, rheumatologists, and endocrinologists, among others. At least that is what we advertise—that we cover a large number of conditions that manifest themselves in the lower extremities. Agreed that we are required to have a certain level of knowledge of these various specialties, since we are generalists of a particular body region, but to do this effectively, we need to be better educated in the overall medical aspects.

If we want to be considered equal or equivalent to our MD and DO peers, then we should do the following:

1) Increase the amount of medicine training our colleges provide to podiatric students. A few of the schools already do this, especially the ones that are actually integrated into an allopathic or osteopathic medical college.

2) Increase the amount of medicine rotations our residents receive while in training. Rotations that have our residents functioning as an integral member of the service should be favored over "observational" types of rotations.

3) Podiatrists in practice should be required to maintain and demonstrate a certain level of medical knowledge. This could be documented by designating an amount of yearly CME requirements for medicine the way radiology CME is currently required in a few states.

4) Other types of CME should be made available online for general medical knowledge expansion, the way PRESENT e-Learning Systems has made many of these topics available.

We need to teach our students and residents to look above and beyond the foot and ankle when treating their patients. In fact, this is easily the more complex part of podiatric medicine. Understanding why a patient should or should not have a surgical procedure and the medical issues leading up to that surgery are as important as acquiring skill in dissecting the foot or inserting a screw. We all know there's a patient attached to that ankle, but do you know enough medicine to understand what's happening with that patient? Are we physicians? Or is that just podiatric lip service? The answer is up to you. **PM**

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