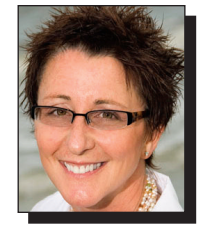
Mark Caselli, DPM

Louis DeCaro, DPM

Richard Jay, DPM



Karen Langone, DPM

Yaron Raducanu, DPM

Building Your Podopediatric Practice

Our expert panelists discuss current topics in this subspecialty.

BY MARC HASPEL, DPM

Pediatrics is one of podiatric medicine's best kept secrets. From afar, observers could easily assume that the profession of podiatric medicine and surgery involves purely adult and geriatric care. That couldn't be farther from the truth. In fact, the treatment of children and children's foot problems should be a vital part of common podiatric practice. Besides the direct benefit to those children impacted by foot problems, from a practice standpoint, podopediatrics can be a valuable source of sustaining referrals in that once the care of children is entrusted to a podiatric physician, the care of other family members will most likely soon follow.

Acknowledging this important part of podiatric practice, *Podiatry Management* has invited several leaders in the field of podopediatrics to share their thoughts on various topics, including conservative and surgical handling of conditions as well as valuable practice management tips. They also graciously offered recommendations for those podiatrists interested in expanding this potentially strong part of their practices.

Joining this panel are:

Mark Caselli, DPM is adjunct professor, Department of Orthopedic Sciences, NYCPM, adjunct professor,

Ramapo College of New Jersey, fellow, American College of Sports Medicine, fellow, American College of Foot and Ankle Pediatrics, former chairman, Department of Orthopedic Sciences and director of Pediatrics, NYCPM.

Louis DeCaro, DPM specializes in pediatrics with a special interest in sports medicine and biomechanics for both adults and pediatrics. He is vice-president of the American College of Foot & Ankle Pediatrics (ACFAP). He is currently in private practice with an office in West Hatfield, MA. He is a member of the surgical & medical staff at Franklin Medical Center and Holyoke hospital. Dr. DeCaro is the founder/director of an adult & pediatric biomechanics gait lab, which takes place biweekly at his office.

Richard Jay, DPM has dedicated the last three decades to his foot and ankle surgical practice and to medical education. He is a professor in Foot and Ankle Orthopedics at Temple University, former director of Pediatric Foot and Ankle Orthopedics at Temple University, and former director of the Foot and Ankle Surgical Residency Program and Medical Education at the Graduate Hospital in Philadelphia. He is the past president of the Ameri-

Continued on page 98

can College of Foot and Ankle Pediatrics and former pediatric surgery editor of the Journal of the American College of Foot and Ankle Surgery. Dr. Jay is presently in practice at Cumberland Orthopedics Regional Medical Center in New Jersey and is the Chief of Foot and Ankle Surgery (Med. Ed.).

Karen Langone, DPM is treasurer, American Association of Women Podiatrists, past president, American Academy of Podiatric Sports Medicine and lead clinical director, NYS Fit Feet, Special Olympics International.

Yaron Raducanu, DPM is fellow, current president and past vice president, American College of Foot and Ankle Pediatrics. He is board certified by the American Board of Podiatric Surgery, adjunct clinical professor, Temple University School of Podiatric Medicine, and attending podiatric physician, Temple University Podiatric Surgical Residency.

PM: *What is your feeling about the effectiveness of splinting to manage foot deformities once children become early ambulators?*

Caselli: Once a child becomes ambulatory, splinting can be very effective in managing certain foot deformities, and should be used post-operatively or post-serial casting for talipes equinovarus or metatarsus adductus correction. This can be well into the child's early ambulatory period to maintain correction. An open-toed straight last or abducted last shoe should be used for most hours of the day and night. The shoe can be modified with a felt bar extending from the base of the 1st metatarsal to the distal end of the shoe to provide a snug fit and maintain the foot in a rectus alignment. This type of shoe can be used as the initial treatment in the early ambulator with metatarsus adductus or in the child with a residual adductus

Continued on page 99

Once a child becomes ambulatory, splinting can be very effective in managing certain foot deformities, and should be used post-operatively or post serial casting for talipes equinovarus or metatarsus adductus correction.—Caselli

deformity after other forms of treatment for talipes equinovarus or metatarsus adductus.

Open-toed straight last shoes are made in sizes to accommodate two to three year old children. They should be worn 22-24 hours a day to be effective. I often provide two pairs of shoes, one for day and one clean pair for night use. The child's foot should be evaluated weight-bearing monthly and the shoe re-modified. This should be continued until the foot remains corrected for at least four to six months. I then recommend that the shoe be worn in the evening until it no longer fits. Night splints or AFOs should be used at nap time and in the evening, following ankle equinus correction in an early ambulator for at least four to six months after the equinus is resolved.

DeCaro: With reference to most early foot deformities, I am a big believer in controlling the calcaneus because, until the age of six, the calcaneus plays a huge role in creating forces on the rest of the foot. Therefore, in a patient with juvenile HAV/hammertoe, controlling the heel in varus in a very early ambulator will prove effective at slowing down whatever deformity may be there or waiting to worsen. In other words, I splint with a deep heel cup. I don't think that taping joints to change angulations is particularly successful. I would, however, never discourage parents from keeping certain joints splinted in improved positions.

As long as the biomechanics are not being compromised through splintage, allowing the ligaments and joint capsule to settle in a more corrected position during maturity can only help the situation.

Continued on page 100

In cases of metatarsus adductus, in particular, I am a frequent user of the Wheaton brace. I find that splinting the foot nightly in a more corrective position helps to reshape and/or hold the midtarsal ligamentous structure.—DeCaro

In cases of metatarsus adductus, in particular, I am a frequent user of the Wheaton brace. I find that splinting the foot nightly in a more corrective position helps to reshape and/or hold the midtarsal ligamentous structure.

Langone: I agree that splinting can play an important role in treatment but it should never limit ambulation or impair the young walker's investigation of movement.

I have been using cryotherapy or having 60% salicylic acid compounded for my wart treatments.—Langone

Raducanu: I too believe there is a use for splinting, but would prefer to get these kids in casts before they start ambulating. There is an advantage to splinting if there is no other alternative, age wise, but my feeling is that, at that point, you are only trying to reduce the deformity somewhat until you can address it surgically. I'm quite sure that just about any deformity, if addressed soon enough, and when the child is young enough, can be cast out. The trouble is that these problems are either not identified early enough or the parents are told that the child simply "will grow out of them."

Q ***PM:*** *What new or available techniques are you selecting in the treatment of plantar verrucae in children?*

DeCaro: I use duct tape therapy (weekly application directly over the wart for six treatment cycles) and oral cimetidine (300mg/kg given TID in divided doses over four to six weeks). I try to stay as conservative as possible. I find that most verrucae in kids possess similar traits, which allows me to avoid possible surgical complications such as scarring, infection, and further discomfort. Overall, I feel that by stimulating an immune response by both the duct tape and oral cimetidine, I achieve rapid resolution of the warts. There are times, however, when I must resort to less conservative measures.

Caselli: There are many factors in an individual's susceptibility to developing and resolving a wart infection, including the child's immune system and the condition and environment of their skin. This often leads to a great variation in the time involved in treatment and the success of any type of treatment. It has also been my experience that most treatments over a period of time result in success. Because of this observation, I select a treatment plan with two main goals. Firstly, in order to do no harm, I do not use any treatment that can result in scarring of the skin, especially the plantar surface.

Secondly, I attempt to cause minimal to no discomfort. I employ gentle sharp debridement to "pinpoint" bleeding. With good technique, the child should experience minimal discomfort. I stop as soon as the child complains of pain. I cauterize the bleeding with silver nitrate. If that stings, I immediately dab the area with cool water. If the child's skin is hyperhydrotic, I have the parent apply a drying agent. If the skin is excessively dry, then a moisturizing agent is used. This appears to help resolve the infection. For young children, weekly visits are necessary. Patience is vital, on both the part of the child, parents, and treating doctor.

Langone: Put simply, I have been using cryotherapy or having 60% salicylic acid compounded for my wart treatments.

Raducanu: One of the doctors I work with introduced me to using topical Aldara under occlusion, and I have seen great results with kids if their parents are diligent with the treatment protocol. I also happen to

Continued on page 102

think that oral Cimetidine is underutilized. I find it really helps.

Q ***PM:*** *How are you treating cases of pediatric onychomycosis and do you approve of oral medication for that condition?*

Langone: I use manual debridement and topical meds. I do not use oral meds in the pediatric population.

DeCaro: I also do not approve of oral medication in children for the treatment of onychomycosis. I actually like topical Formula 3 for kids with onychomycosis. I find the therapeutic reasons for selecting Formula 3 in pediatric therapy include: it is non-systemic, safe, and it's effective. In addition, for active kids, the oils in that product restore the nail's natural mechanical properties allowing the nail unit to absorb impact and micro-trauma, preventing the tearing of the plate from the nail bed. These tears become natural portals of entry for fungus to advance proximally.

Caselli: It appears that most cases of pediatric onychomycosis involve an underlying nail pathology which results in a nail deformity making the nail susceptible to a fungal infection. Some of these pathologies include conditions such as pachyonychia congenital, ectodermal dysplasia, and psoriasis. Another common etiology is nail trauma causing a subungual hematoma and damage to the nail matrix, which results in deformed, thickened toenails. Chronic paronychias can also cause nail matrix damage and deformed, thickened toenails.

My primary approach is to determine the etiology of the deformed toenails. If it is a congenital problem, and cannot be corrected, then treatment is directed to maintain the nails in as good a cosmetic and functional condition as possible with careful debridement, filing, and use of high concentration urea preparations when the child is older. Permanent removal of the toenails may also be an option in the older child. If the nail deformity appears to be traumatic in origin, then I address footwear and/or foot function that may contribute to the nail trauma and allow time for the nails to re-grow. In either case, I do not recommend oral (systemic) antifungal medication in children. These medications are not addressing the primary etiology of the problem and, if they do result in some improvement in the nail, they would have to be used for long periods of time, which is contraindicated for the present medications.

It is essential that excessive pronation be neutralized as soon as a child is old enough to stand.—Jay

Q ***PM:*** *What is your recommendation for children regarding hard versus soft shoes?*

Jay: It is not a matter of a soft flexible shoe versus a rigid shoe; shoes are meant to protect against the environment. By maintaining the child's foot in its proper biomechanical alignment internally during development, foot function improves and deforming forces are limited.

It is essential that excessive pronation be neutralized as soon as a child is old enough to stand. The goals are to improve the child's function and to prevent future foot problems associated with flatfoot; this is accomplished with proper alignment of the foot during development. Inner-support systems to control the three biomechanical planes are essential. Unfortunately, the shoes in production now do not provide this support. It is the podiatric physician's job to construct this inner support with custom orthoses, which may be expensive, but are needed.

Raducanu: I really think that children should be in harder shoes. I know certain companies profess that kids should be in softer shoes, but my gut tells me otherwise. Neither of us have hard data to show, but new walkers need support and protection. A softer shoe certainly doesn't offer as much protection and, as children are learning to walk, a firmer support base just makes sense to me. Someone once mentioned that children need softer shoes to help with normal gait patterns, but new walkers' gait patterns are nothing like their adult counterparts. Until there is a company willing to fund a good study, all of this is just conjecture in any case. It's just a bunch of us throwing around opinions.

DeCaro: Those of us who specialize in podopediatrics are commonly faced with the challenge of treating not only by proper orthotic or brace control, but also finding the correct shoe to complement the care. The common goal with all pediatric foot orthoses is to help children gain mobility, ultimately giving them a better quality of life. Proper support gives a child the gift of running, jumping, and playing with confidence and stability. Providing the orthotic device is only half of the solution; proper shoe fit is equally important. Most children with mild to moderate flexible flat foot benefit from sturdy shoes to adequately hold a pre-fabricated or custom orthotic device as an important part of their treatment. If the shoe is too flexible and they wear an orthotic device, it can be analogous to taping orthotic devices to the feet and having the patients walk on the couch. The sheer instability created can jam the hard devices into the feet and cause pain.

If children do not need an orthotic device, then the sturdiness of the

Continued on page 104

shoes should depend solely on the activity they are performing. Similar to adults, children should wear sport-specific types of shoes to help with things such as lateral stability in sports like basketball and tennis, to more firm-lasted shoes for sports such as those that involve fields with uneven surfaces.

Caselli: The most important consideration in children's shoes, far out-weighing hard versus soft, is proper fit. First walkers' feet grow very rapidly. It is not uncommon for them to outgrow shoes every two to three months. There appears to be no harm in using either type of shoe. There are advantages and disadvantages to each type of shoe, however, for certain situations. The main purpose of a shoe is to protect the foot from the environment. The size of first walkers' feet are disproportionally large compared to the length of their legs, and coordination is immature.

In normally functioning children, I recommend soft shoes. First walkers appear to function better with less tripping and falling in soft shoes. This is especially true if the children have internal rotational alignment (in toe) disorder. Those children with low muscle tone and extreme ligamentous laxity, as seen in Down syndrome, or those who have excessive external alignment (out toe) problems seem to function best in early ambulation with broad-soled rigid shoes. These shoes give children greater initial stability for standing independently and taking their first steps.

As children mature, I gauge the rigidity of the shoes necessary for them by their ability to maintain the lower extremity in a relatively rectus alignment. With greater pronation, ligamentous laxity, and lower muscle tone, I feel that more rigid types of shoes or sneakers are recommended.

PM: *Turning to pediatric surgery, what is your feeling about performing TALs versus gastroc recessions in children for certain conditions?*

Jay: Determination of ankle joint dorsiflexion range of motion is performed with the patient in the supine or prone position. If dorsiflexion is less than ten degrees beyond the perpendicular, the muscles producing the equinus are identified by the Silverskiold test. When ankle dorsiflexion with the knee flexed is adequate, gastrocnemius lengthening alone is performed. Gastrocnemius recession or Achilles tendon lengthening is the most commonly used adjunctive procedure to the subtalar arthroereisis. The gastrocnemius recession, however, should be performed as the primary procedure to address the equinus. Studies have shown that the effect of limited ankle dorsiflexion from a tight Achilles cord results in the collapsing of the medial arch. The gastrocnemius and soleus muscles, through the Achilles tendon, provide the most powerful dynamic arch deforming force on the foot

DiGiovanni and colleagues studied patients who had triceps contracture and foot pathology to distinguish between gastrocnemius equinus versus gastrocnemius soleus equinus. They found that ankle dorsiflexion of five degrees or less with the knee extended is evidence of gastrocnemius equinus, and dorsiflexion of ten degrees or less with the knee flexed is evidence of gastrocnemius soleus equinus. Root and colleagues found that a minimum of ten degrees of pas-

Continued on page 106

The most important consideration in children's shoes, far out-weighing hard versus soft, is proper fit.—Caselli

sive ankle joint dorsiflexion in the propulsive phase of gait is needed in an individual, or else compensatory subtalar joint pronation will occur. Passive dorsiflexion range of motion of the ankle between five and ten degrees results in no significant change in frontal plane rear foot kinematics during the stance phase of gait. Root and colleagues found that the maximum amount of dorsiflexion in the stance phase of normal gait occurs just before heel lift with the knee extended. Thus, it is important to have adequate dorsiflexion, which is insufficient with equinus deformity, making this a significant factor to address in flatfoot deformity.

The effectiveness of performing a gastrocnemius recession with subtalar arthroereisis was shown in the study performed by Cicchinelli and colleagues. Gastrocnemius recession with subtalar arthroereisis has showed a correction of nineteen degrees (range eleven to thirty-four degrees), in the transverse plane; whereas arthroereisis alone shows eight degrees (range from negative one degree to fourteen degrees), of correction. This pattern of correction did not affect the sagittal plane, which could indicate that equinus has a clinically important effect on transverse plane deformation of the subtalar and midtarsal joints. Furthermore, they found the results to be surprising for the combination of arthroereisis with gastrocnemius recession and medial column stabilization. The results showed a smaller degree of correction, median four degree (range from negative nine to nineteen degrees), compared with the other two groups, especially with the results from the gastrocnemius recession with subtalar arthroereisis. These results show that the gastrocnemius recession with subtalar arthroereisis has a statistically significant effect on the degree of radiographic correction of transverse plane elements of pes planovalgus. Therefore, gastrocnemius recession with subtalar arthroereisis seems to be a good choice for the correction of large transverse plane deformities.

Raducanu: I am a firm believer in gastrocnemius recession for the pediatric population. In my lecture on the topic, I discuss literature that points to the fact that you have much more control of the outcome on range of motion with that procedure. There is less risk for rupture post-procedure. I tend to favor percutaneous Achilles tendon lengthening in patients who need it due to co-morbidities, but find that, with pediatrics, that is not much of a consideration.

gastrocnemius is cut, however, and the soleus is spared, the loss of power to the gastroc-soleus complex is approximately ten percent. Post-operatively, these patients do well because they have the adjunctive control of the arthroereisis implant. The gastrocnemius recession eliminates the pronatory force and prevents the sequalae associated with the pronatory force of equinus.

Gastrocnemius recession or Achilles tendon lengthening is the most commonly used adjunctive procedure to the subtalar arthroereisis.—Jay

PM: *What is your preferred technique for subtalar implants in children?*

Jay: The flexible flatfoot is made worse by equinus, which prevents normal dorsiflexion. Equinus may be the primary deforming force in the flexible flatfoot. Regardless of the origin of the equinus, it must be addressed at the time of surgery. As the talus assumes a more vertical and medial position, the calcaneus is forced to rotate posterolaterally from its position under the talus. The sustentaculum tali loses its supporting position beneath the neck of the talus as the calcaneus subluxates laterally. Because the hind part of the foot cannot be dorsiflexed, dorsiflexion then occurs at the mid-foot. A breach of the mid-part of the foot (a rocker-bottom foot) may result, with the hind part of the foot in valgus angulation and the fore part in abduction.

The sinus tarsi increases in size as the child matures, making the absorbable implant practical for use since it takes about fifteen months for it to resorb. This allows adequate time to maintain the correction achieved with the gastrocnemius recession. With the gastrocnemius lengthening, the patient does not have instability at the knee joint during gait. Once a tendon is lengthened, the strength is reduced by approximately twenty-five percent. When the

Again, it is my opinion that, in cases of pediatric flatfoot, it is essential to correct the equinus by performing a gastrocnemius recession and subtalar arthroereisis as an adjunctive procedure. Surgery performed at a young age provides a lasting correction of the deformity, and improves the biomechanics, preventing problems associated with equinus and excessive pronation of the foot. No matter what subtalar implant is chosen, if used in the correct patient, these procedures will prove to be effective with the lengthening.

Raducanu: I recently started using the Hyprocure Implant (Gramedica) and have had great results with it. There is a learning curve, and it does take a bit more technique to implant it correctly, but I do find that so far I haven't seen as many slip, thereby needing fewer removals. They are also very well-tolerated, and once you get the technique down, they are quick to put in.

PM: *How do you ensure compliance in the pediatric population in terms of parental and/or guardian involvement*?

DeCaro: Compliance is really not much of an issue at all. Most parents/guardians advocate for their child and, with thorough education,

Continued on page 108

there is usually no concern about compliance. The one issue that I do find is that when the patient is improving, often times parents/guardians forget to make an appointment for re-evaluation. I try to stress the importance of follow-up visits and give them the timeline for the next appointment. When I do all of these things, especially the educational part, non-compliance is seldom a problem. In fact, after their visit with me, parents often make an appointment for themselves and/or siblings of the patient.

Jay: To ensure compliance, I recommend having parents be careful not to telegraph their anxiety to their children. Parents should try to be upbeat, positive, and supportive. Parents who display the most fear and anxiety by words or actions often have the most fearful children. It is important to relay this to them prior to the examination. While the family is waiting for their appointed time, help distract the children by having books in the waiting room and toys to encourage them to play quietly. Help children refocus their anxiety by coming to the office prepared with a favorite book or toy from their home, I have my staff request this of parents of patients at the time the appointment is made. Don't try to stop children from crying. Try to let parents know that this is okay. If children are hurt or upset they will cry. It is a natural release.

The parents should realize this as well. Just support the children and have the parents either touch or quietly reassure them. If children ask for information in preparation for the examination or treatment, offer as much detailed information as is available. As the physician, if you are the one to initiate the discussion, then offer minimal information. Don't give too much information to children who do not ask for it. Do not misinform them about what is going to take place during the office visit. Children should receive accurate, honest, and matter-of-fact information. The parents should be advised that you, as the physician, are trying to provide proper care to them, not only technically but also psychologically. The parents should be aware and tell you if there are any special needs for their children.

Raducanu: Sadly, compliance is a problem whether you're dealing with adults or children. The best way to manage this situation is to write everything down for the parents or provide documentation that explains the treatment protocol. Even in those situations, compliance is an issue. I can usually tell almost immediately if the parents are involved with their children, and then if I notice that they are, I worry less about compliance. Families are busy, and things tend to slip through the cracks even more, even if the intention is there.

The one issue that I do find is that when the patient is improving, often times parents/guardians forget to make an appointment for re-evaluation.—DeCaro

Langone: Most of our pediatric patient visits are initiated by parents or pediatricians. Therefore, most parents are present at the office knowing that some type of intervention will be necessary. Young children easily accept treatment, as well as our young athletes. Some adolescents, particularly severely fashion-conscious ones, worry about footwear if we initiate orthotic therapy. We have worked, however, to find shoes that keep everyone happy. Similar to adolescents and parents accepting the psychological trauma of orthodontics, they are generally accepting of our treatment as well.

Caselli: I invite both parents, if present, into the treatment room even if only one of them brings the child in. This gives both of them a chance to ask questions if they don't understand the diagnosis and/or treatment plan, and both to agree with the doctor that this is what should be done. It is important to know that both parents are "on board" with the plan in order for the treatment plan to be successfully carried out. For older children, pre-teens and teenagers, who might initially come into the treatment room on their own (either their preference, or their parent's preference), I invite the parent into the treatment room. I will ask permission from the patient (though not necessary) and explain that the parent is paying the bill and they should know what they are paying for. This maintains the child's/adolescent's feeling of independence and at the same time increases the parent's involvement in the child's treatment. If the child is from a divorced home, even though they usually present with one parent, most often their mother, I will request that the diagnosis and treatment be discussed with the other parent. This greatly improves both the doctor-parent relationship and treatment compliance. At every visit I ask the patient to explain to me what treatment has been performed since the last visit. I conclude each visit by briefly re-explaining the diagnosis, treatment and goals. This can be as simple as stating "For this problem, we are doing this, and we hope to accomplish that".

Q ***PM:*** *What tips can you offer for creating a welcoming office environment for children?*

Raducanu: A clean, well-lit office is a start, but that should be a general rule anyway. It is important that the staff can handle the pediatric population as well. In a pediatrician's office, that's a given, but in our offices, perhaps not so much. I'm also less and less concerned with the "white coat" issue, as little children tend to be more fearful of the nursing staff than the doctor these days. The

Continued on page 110

nurses are the ones giving shots at the pediatrician's office, so the children are less afraid of the doctor. Unless a patient is being seen for an ingrown nail, I always will show the child both my hands, open with palms facing them, to show them that I have no shots in my hands. I also tell them "no shots" and that usually puts them right at ease. I also look them in the eyes when talking and involve them in the conversation (age appropriate of course). I don't lie to them either. If something is going to hurt, such as an injection, I tell them so. I don't scare them, but honesty is the best policy. I think they appreciate the honesty. If children catch you in a lie, they'll never trust you again. If it's going to hurt, prepare them and they won't mind it so much.

Langone: We generally hold blocks of time for younger patients. Entering a waiting room where other children are present is helpful in creating a friendly environment. We also keep children's books and lots of new markers and coloring books for patients. We are parents ourselves and truly enjoy having children in the office. We have fun with them and they enjoy their time in the office.

Caselli: My waiting room is supplied with a variety of books/magazines for children of different ages. When a parent presents with the child, they are directed to these by our office staff. I only keep items that require some parental assistance. This deters parents from leaving the child alone while they catch up on reading "People" magazine. I then encourage the child/parent to bring the book into the treatment room. At the end of the visit, the child is given an age-appropriate toy or sticker. In order to observe the child's gait, I will ask the parent to have the child walk with their shoes on in the waiting room as soon as they present to the office. While the child is happy/content sitting in the waiting room, the parent is asked to remove the child's shoes and lower extremity outer clothing, if appropriate. When it's time to be examined, the treatment room door is left open and the parent is asked to let the child walk through the waiting room and down the hallway to the treatment room. This allows the doctor to observe gait without shoes and determine weight bearing foot alignment. This may be the only chance to do this if the child becomes frightened and uncooperative. I will also encourage the child to walk into and around the treatment room on his/her own (under a watchful eye) while I am speaking to their parents. What often happens is that the child (toddler) will often attempt to climb onto the treatment chair and will be happy when the parent assists. Over the years, to my surprise, this is a more common than not scenario, thus presenting both the child and parents with a more welcoming office experience.

Entering a waiting room where other children are present is helpful in creating a friendly environment.—Langone

Jay: My recommendations for the office of a general foot and ankle surgeon who also caters to the pediatric population are as follows. Keep a child-friendly environment for the convenience of the parents. What might be advisable, if affordable to a practice, is to have a child-friendly area where children can play in the reception area. This will welcome and transition them into your practice. This will establish a nice, comfortable control for children prior to their examination. Always make sure that this child area is conveniently situated so that the parents can supervise their children and not rely on your staff.

It will not be necessary for you to create an elaborate play area but rather just some furnishings that will allow children to integrate within your practice. Originally, I thought a separate area for children to play was a good idea to keep them away from the remaining population of my practice; however, this just allowed a free-for-all environment. After realizing this, I found that integrating the children into the normal practice was beneficial as the other patients noticed that my practice also caters to young children.

In this day and age with video games and electronic components, I don't feel that it is absolutely necessary to occupy children with these items within an office setting. Certainly, they will distract them, but it may make them too dependent upon the electronic game, making it more difficult for them to exit for the examination. It looks and sounds great for children, but keep the area simple; it's just a temporary spot. Children are to be supervised by the parents at all times, and strangers are not to interfere with their activities during this temporary distraction. Be sure that your staff cleans the toys, work areas, desks, or little seats that the children use.

Parents want to know that you have respect for their children and also respect for them. Another good practice to make parents and children welcome in your practice is to never have children unattended; the parents should always be present or visible.

PM: *What recommendations do you have for podiatrists looking to expand the podopediatric portion of their practices?*

Langone: I recommend that podiatrists talk to their local pediatricians and nurse practitioners about what they are able to do for pediatric patients. They should educate them about the need for foot exams and gait exams as part of the annual pediatric exam and their ability, as podiatric physicians, to aid pediatric pa-

Continued on page 112

tients when problems are noted.

Caselli: The two major recommendations that I have on building the podopediatric part of a podiatry practice are: heavily marketing in the areas of podopediatrics that the interested podiatrists would like to pursue, and obtaining as much knowledge and clinical training in these areas of podopediatrics as possible in order to provide the best care to pediatric patients when they present to the office.

Marketing the pediatric part of a practice may include podiatrists presenting themselves to local children's shoe stores. I recommend speaking to owners and asking to leave business cards; offering to set up times to give talks on children's foot problems at the shoe store. Also, consider contacting key individuals of the local children's sports teams and offering to give lectures to the parents on foot health and safety. Both local public and private schools should also be approached. In addition, podiatrists should contact local physical therapy groups or early childhood intervention centers that treat children with neurological or myopathic diseases such as cerebral palsy, Down syndrome, or muscular dystrophy. Many of the children in these programs require foot orthoses as well as other podiatric foot care. Moreover, podiatrists should introduce themselves to the local pediatricians. After treating children in the office, podiatrists should also send the letters to the pediatricians with their clinical findings and treatment plans. Lastly, podiatrists should not forget to mention in their advertising that they treat children's foot conditions.

Jay: I have been in practice for 35 years and I truly believe the only reason that I have built a formidable pediatric practice is my respect of children, their parents and the referring pediatricians. It is a team effort to treat children and all too often, we forget this mission. I direct my interview and examination with the children in mind, I want the parents to know I understand their concerns and I want the children to know that I am treating them as people. The children, just like the parents, are fearful of podiatrists, as of any strangers; a comfort level must be established. I feel podiatrists must talk to the parents and the children on equal levels. They should not be dismissive of their concerns. When treatment is completed, podiatrists should make sure to send complete reports to the pediatricians, even if the children were not referred in the first place.

Kids are amazing little people who can sense right away whether podiatric physicians are the kind of people they will like or not. —Raducanu

Raducanu: The first thing to do is for podiatrists to realize whether that's a population they want to help. Kids are amazing little people who can sense right away whether podiatric physicians are the kind of people they will like or not. As soon as they see them, they've already made up their mind. If podiatrists are not the type to understand and accept that, they will be at a disadvantage. The other thing is to really make the parents comfortable. If podiatrists can do that, their practices will start to overflow with pediatric patients.

It also helps if podiatrists have little ones themselves. They meet more people that way and spend more time at pediatricians' offices (for better or worse). Truly, podiatrists just have to love working with children. It makes podopediatrics much easier than most colleagues in our profession make it seem. There used to be a gap in that niche, but today that gap is closing. PM

Dr. Haspel is senior editor of this magazine and is past-president of the New Jersey Podiatric Medical Society. He is a member of the American Academy of Podiatric Practice Management.