FEATURED ARTICLE

Perioperative Medication Update for Podiatric Surgeons

by Dr. Patrick Burns, DPM

Many of us see and treat patients on a daily basis with a complicated past medical history. There are many systemic processes that manifest with foot and ankle conditions so it is imperative that as a specialty we acknowledge this and at the same time be able to intelligently assist in the perioperative management.

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President's Message

This is my first opportunity to speak with you as President of the Board of the Pennsylvania Podiatric Medical Association. I take the position of President in an unprecedented time during which we are all trying to navigate the public health implications of COVID 19 and its impact on our lives, our patients’ lives, and our practices.

At the same time that we are adjusting to this new normal, we are facing what appears to be a kind of identity crisis within our profession. This crisis is unique to our history and, I feel, needs to be addressed.

In May of this year, the APMA Board announced the creation of a White Paper and a Resolution that was submitted to the American Medical Association with the expressed purpose of requesting that the AMA “study” our profession to deem our students and certain practitioners eligible to take the USMLE. By taking and passing the USMLE, according to the APMA endorsed White Paper, we doctors of podiatric medicine could demonstrate to the “public” that they should have a high degree of confidence that we practice to the same standard as Medical Doctors and Doctors of Osteopathy.

This action, taken by the APMA Board, has caused six months of consternation and confrontation between our Board, the Boards of eight other states, and the APMA Board. Our concern with this APMA action was a lack of widespread discussion of how the APMA enacted this decision and a failure to recognize the effect that adopting the USMLE as a “common standard” would have on our education and training practices.

We have successfully attained what we initially asked for through concerted action of our Board and the other Boards of APMA component states. This is a forum in which all sides of this issue may be heard. It is our intent that a general point accepted path to parity can be adopted.

I am recounting these last six months for two reasons. First, it demonstrates how cooperative action can achieve a defined goal; but second, it exemplifies what can be achieved by working within the rules of our national and state Association. Let me explain. When we first voiced our concerns over the actions of APMA, we determined to express and manage those concerns within the Bylaws of APMA and the rules of the House of Delegates. That is because we all recognize that we are a very small profession and, at the end of the day, we all need to speak with one voice. We are heading, now, in that direction.

This is all a lengthy explanation to make my principal point. This year, podiatry has the highest chance of passing national legislation then we have had in the past seventeen years. Title XIX reform (The HELLPP Act) has been “restored” in both the House and Senate. RIGHT NOW, we have to exert more concerted action. We all must take ten minutes and go to the APMA web page and write to our Federal Representatives and Senators and request that they co-sponsor the HELLPP Act. This takes a concise amount of time but is very effective (https://apma.quorum.us/signup/)

Finally, this is the year to give to the APMAPAC. PAC funds are integral to the prospect of legislative success. Passing Title XIX reform achieves what APMA was trying to accomplish through its White Paper and AMA Resolution. Let us make that an effort that is no longer necessary.

Before I close, I am taking this opportunity to thank you for assuming this Presidency. My Predecessor, Sabrina Minhas, has served a COVID imposed two terms and has demonstrated how our Association can become more valuable and essential for our membership. I intend to follow that same path, and I hope to be as successful.

Laura Virtue-Delayo

[Image of Laura Virtue-Delayo]
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Thank you!

Special thanks to Susan Kramer, for all your years of service as Communication Director and contributions to the PPMA newsletters. You will be missed!
If we are taking on the responsibility of operating, then we also need to take accountability for the perioperative process. As the surgeon, you may not be actually prescribing or directly managing all of your patient’s medications but you should be aware of them. You must know your patient’s history, and recognize what other specialties to consult in order to help make the perioperative process safe. Preoperative clearance in many cases is not just the primary care physician. Patients may have an endocrinologist, rheumatologist, hematologist, cardiologist, oncologist or other provider prescribing medications that we are not acquainted. It is understandable be unfamiliar with certain medications. Although this can cause stress and create confusion when it comes to the patient being medically managed perioperative, it is our responsibility to be in contact with those who can guide us through the appropriate management.

Many time this starts with anesthesia. They are a great wealth of knowledge can help provide guidance. Most anesthesia departments have a list of preoperative requirements, including lab work, chest Xray, EKG etc. This is a good place to start your planning, but many of the medication decisions will come from your consults and your own choices. We will focus on a few of the most common questions and conditions keeping in mind there are many variables such as acuity and extent of surgery so decisions need to be made based on your experience and of course case-by-case.

Blood thinners are a common question. They can range from simple aspirin or NSAID to other prescriptions such as Plavix or coumadin. Recommendations can vary widely. With regard to aspirin, in elective cases, most would recommend holding it for 7 days before a procedure. Unfortunately, if aspirin is being utilized on a regular basis as it is many times for its vital cardiovascular effects, discontinuing it may have undesirable affects. Aspirin should only be discontinued in these circumstances where the risk of bleeding is significant, or the consequence of a bleed would be significant such as retinal or spinal surgery. For most of our foot and ankle procedures, aspirin would not need to be discontinued but should be discussed with the patient’s primary care or cardiologist.

NSAIDs are another common drug category with questions. Again, that can vary depending on the actual NSAID and its half-life. Most recommend stopping NSAIDs five half-lives before procedures, typically about 3 days. Not only can this class inhibit platelets and increase bleeding time, but may have effects on renal function and accentuate dehydration. In a similar category, COX-2 inhibitors such as Celebrex (celecoxib), are frequently encountered in our patients as they are used for musculoskeletal aches and pains. As a class, COX-2 inhibitors have shown no effect of platelet aggregation or bleeding times but can have similar renal effects which should be considered. The recommendation is COX-2 inhibitors can be continued perioperative (1).

In general, anticoagulation is a common consideration for many of our procedures. As many of us provide care for...
those with concomitant peripheral vascular disease, coronary arterial disease or a history of thromboembolic events we must be familiar with this overall class of medications. The types and number of oral anticoagulants has grown over the recent years and it is best to have consultation and guidance by the anesthesia team and prescribing physician.

For those with PVD, antiplatelet medications for inhibiting platelet aggregation are common adjuncts to their treatment. Of those, Plavix (clopidogrel) prevents adenosine diphosphate (ADP) from activating platelets. It can persist for 4 to 8 days after stopping therapy. If Plavix is being utilized with recent cardiac stent placement, within 6 weeks, it should be stopped for as short a time as possible. If there is no risk of major bleed then it should be stopped 3-5 days before procedures, and then started as soon as possible after surgery. For most of our encounters however, Plavix is being utilized for lower extremity PVD and may not need to be stopped at all. This is based on the case type and extent of surgery. If there are questions or concerns, speak with the vascular surgery team. Pletal (cilostazol) is another common medication in our patients with vasculopathy. It also inhibits the aggregation of platelets as well as promotes vasodilation. It should be held 5 days before surgery with similar considerations as Plavix. If the bleeding risk is low for the procedure to be performed, in may be continued without interruption (2).

When looking at anticoagulation medications, Coumadin (warfarin) is utilized in many of our patients for long term anticoagulation. Warfarin inhibits the vitamin K coagulation factors and as such there are ways to reverse its affects if required quickly. Otherwise, it is recommended to stop its use 4-5 days prior to surgery but again varies based on the surgery to be performed. Low risk surgery may not require stopping warfarin. For this, many times I consult with anesthesia and use their guidance. Monitoring the international normalized ratio (INR) is necessary, and although you may proceed with surgery while the patient is on warfarin, it may change the type of anesthesia offered so the surgeon should be aware. Anesthesia may not offer regional or spinal blocks with an INR that is too high, but the case can still be done based on your judgement with other forms of anesthesia. Traditionally an INR < 2 is acceptable as safe but again depends on the type of surgery. Of note, warfarin has the added issues of food and drug interactions and utilizes the liver cytochrome P450 enzyme which may require further consideration (3).

Direct oral anticoagulants (DOA) have become popular for the prevention of thrombosis and include Pradaxa (dabigatran), Xarelto (rivaroxaban), and Eliquis (apixaban). These are attractive alternatives to the more traditional vitamin K antagonist anticoagulation as they require fewer monitoring requirements, less frequent follow-up, have more immediate drug onset, and fewer drug and food interactions compared to the vitamin K antagonist counterparts. In general, these again seem to be variable. Since a majority of our procedures can be low risk for blood loss, this class can generally be held one day before and one day after the procedure safely (4).

Heparin is a standard medication for anticoagulation in particular with our in-patient procedures. It is actually unfractionated heparin (UH) and is a naturally occurring anticoagulant. It works by activating antithrombin III to accelerate inactivation of thrombin and factor Xa. It has a relatively short half-life of 1-2 hours after injection. The decision to stop heparin may include factors such as monitoring patient anticoagulation with aPTT and the type of surgery to be performed. Heparin is usually held the morning of surgery giving the time for its five half-lives in order to clear, but with low risk for major bleeding there may be no issue and heparin can continue. It is a decision made with consultation of anesthesia and the medicine team (3).

Injectable anticoagulants such as Lovenox (enoxaparin) and Fragmin (dalteparin) work by potentiating antithrombin to inactivate clotting factor Xa. They are sometimes referred to as low molecular weight heparin LMWH anticoagulants as they are heparin based. As a class they require less monitoring than traditional heparin, have simplified dosing, and have less chance for heparin induced thrombocytopenia (HIT). They are common for prevention and treatment of thromboembolic events and at times used to bridge other anticoagulants. Arixtra (fondaparinux) is similar in that it is an injectable anticoagulant that inhibits factor Xa but is not a heparin product so is not a LMWH. Because it has no heparin component, it can be used for patients with a history of HIT. These injectables can typically be held the evening before procedures then restarted the same evening (5).

Hypertension is a common systemic condition with many drug classes and medications for treatment so discussing with the primary care and anesthesia would be recommended if there are concerns. In general, the recommendation is the continue most of these medications with some exceptions. ACE-inhibitors and angiotensin II-antagonists should be held the day of the procedure. Diuretics have a recommendation to consider holding the morning of procedures due to issues of volume loss and hypokalemia. These decisions again should be discussed with anesthesia as they will have their guidelines to assist in the decision (6).

Antirheumatic agents are becoming more common and the list is expanding. In general, these medications should not be stopped without discussing it with the prescribing physician. There should be a preoperative consult placed
for the best recommendations. The traditional disease modifying anti-rheumatic drugs (DMARDs) that are nonbiologic such as gold, doxycycline, and sulfasalazine can continue as usual. Antimetabolite/antiproliferative nonbiologic DMARDs like hydroxychloroquine and leflunomide can also be continued.

The biologic response modifiers are the newer class of DMARD helping to slow progression and limit damage while having fewer side effects. They work by targeting immune system pathways by blocking signals involved in the inflammatory process. They don't suppress the immune system as broad as conventional DMARDs but do have some affect so need to be considered. Medications such as adalimumab, etanercept, and infliximab should be suspended. It is suggested, if possible, surgery not proceed for 1-2 weeks after the last dose cycle and then not resumed until 2 weeks after surgery and only in the absence of wound healing issues (7).

Methotrexate traditionally has been suggested to hold 48 hours before procedures. It is cleared by the kidney and procedure related hypovolemia can lead to less clearance and resultant toxic levels even if there is transient renal insufficiency. However more recent recommendations from the American College of Rheumatology suggests it can be continued.

Corticosteroids should be continued. Long term use, > 3 moths can lead to adrenal suppression and so may require higher doses perioperatively. Anesthesia should be aware and discussion with them prior to the procedure would be prudent (8).

Another large category of medications involves our population of patients with diabetes. There is a growing list of medications to help control blood glucose and many times this is managed by the primary care or anesthesia perioperatively. Some important medications to know would include metformin. Metformin is an oral insulin sensitizing agent and helps restore the body’s response to insulin. Although there is some debate, it is recommended to hold metformin the night before procedures as it has been associated with the development of lactic acidosis. A sliding scale of insulin can be used to cover the time it is held perioperatively. Just as important, metformin should be held in those with renal impairment, or creatinine clearance < 60, who require imaging with contrast. Other oral hypoglycemic medications are typically stopped the day of surgery only and again insulin utilized to cover the perioperative time. Oral medications then resume when the patient is consuming food and fluids noting stress may increase insulin requirements so blood glucose should be monitored closely. Certainly, patients should be optimized if able before surgical procedures and glucose is to be monitored by the anesthesia team and acting on accordingly throughout the process (9).

One last question is the use of herbal and natural supplements. This is a difficult issue as most are impossible to assays because the ingredients are not always highly purified, have unknown bioavailability and may have contaminants. For that reason, it is recommended to stop all herbal and natural supplements one week before procedures.

In closing, there are many foot and ankle procedures performed on patients with comorbidity. It is impossible to know all the current medications and preoperative dosing recommendations but we must continue to stay up to date on new drugs and classes and become familiar with their effects on our patients and their perioperative care. Even though we are a specialty, as the surgeon it is important to take responsibility and ask for appropriate consults and lean on our anesthesia colleagues to help guide patient care. As with most issues, communication will decrease stress and complications associated with these decisions.

REFERENCES


QUESTION:
WHEN TO USE CPT 28297 VS. CPT 28740?

ANSWER:
The CPT Editorial Panel states that any “bunionectomy” must include resection of the medial eminence of the first metatarsal head.

When a first metatarsocuneiform joint arthrodesis is performed by any method in combination with resection of the medial eminence of the first metatarsal head, the single appropriate CPT code is CPT 28297. When a first metatarsocuneiform joint arthrodesis is performed by any method without resection of the medial eminence of the first metatarsal head, the single appropriate code is CPT 28740.

More information can be found by visiting the full article in Podiatry Management Magazine at https://podiatrym.com/Highlights2.cfm?id=2767•
“What happened to Mrs. Baker today?” asks the doctor. “She had a two o’clock appointment and didn’t show up.” Patient no-shows are a daily scheduling occurrence that is more common than any of us would care to admit. Why do they happen? What do we do about them? And finally, how can we prevent them?

Let’s start with “Why?” The reason for no shows from a patient perspective could revolve around many things. Of course the possibility exists that their absence could have been the result of an unavoidable last minute conflict or an unfortunate mishap; and in those particularly rare cases, you find it easy to empathize.

But most likely, one of the following occurred: They were too busy, they forgot, didn’t feel it was a priority, or just didn’t understand the value of going.

Then there are those who make a habit out of not showing, and you can predict two weeks out, thanks to the road-map of red markings in their charts, exactly who they will be.

What do we do about these patients? By intentionally disregarding their actions, we are irresponsibly allowing these patients to diminish the value of our time. Except for those offices who have a rigid policy when dealing with patients who don’t show, e.g., charging a fee or inconveniently re-scheduling them, there is often times, little to no consequence to a patient who fails to show for this appointment, or the last one, or the one before that, or the one, well you get the picture. Sometimes without our realizing it, we allow our patients to sit in the driver’s seat of our practice, instead of taking control of the wheel ourselves; and the only way to avoid unwanted future wrecks is to realize that we need to reposition ourselves.

So how do we do that? First, by attaching value to our time and once we do, make the patient aware that we do. Unfortunately, some patients who have been told by the
Secrets of Success

It is up to each one in the office—beginning with the doctor—to impress upon the patient that a follow-up appointment is suggested for THEIR benefit, not ours. If the patient fails to appreciate that by the time they leave the office, there is a hole in the protocol/system somewhere that needs to be fixed.

It is important for the receptionist to be proactive when making the patient’s follow-up appointment. Again, reinforce the importance. Next, emphasize to the patient the courtesy of a call if he/she cannot keep the appointment; while also explaining that their failure to keep the scheduled appointment could severely limit their chances for rescheduling at a convenient time.

The strategy in this case should be, “Mrs. Baker, if you cannot keep this appointment, we would appreciate the courtesy of a call so that we can then make it available to someone else who’s been waiting to get in. We realize your time is important, and should the situation ever arise where YOU would need to be seen, we would like to be able to offer you the same consideration.”

Remember, when we speak in terms of appointments to the patient, they only translate that into “increments of time”: 15 minutes, 30 minutes, 45 minutes. They are merely time slots in your book to them. So, in addition to conveying the message that our time is valuable, we need to take the extra step to prove it and make them believe it. Think for a minute of the mixed message we send when scheduling two or more appointments in the same time period. And don’t be so naïve to think that they don’t compare appointment notes while they are sitting in your reception room.

You cannot expect a patient to understand the value of that appointment knowing that you double-booked them with someone else and forcing them to wait 40 minutes or more! Maybe the next time they are scheduled, they’ll think it is “no big deal” if they don’t show, with the notion that you already have someone else penned in to fill that “valuable” time slot anyway.

And so, we come to our final question: What can we do to prevent No-Shows? Without starting a debate on the pros and cons of calling patients to remind them of their scheduled appointment, I can only tell you that if you do call, from a patient’s perspective, you continue to live your philosophy by example; showing them that you assign importance to the time you have set aside for them.

In addition, calling your patients to confirm a day or so prior to their appointment allows for two very important things to occur:

1) You can verify your schedule for the next day;
2) You have an opportunity to fill newly vacant appointments with other patients who may be waiting for an opening.

Make your call count—
- Inform your patient that you will call to remind them of their appointment and be sure to ask where they can best be reached.
- Rather than just leaving a message on their machine, you want to call them at a place where you are sure to make a live connection.
- Some prefer home or cellphone, while others, their office phone or email.

It can be argued that there are still the occasional no-shows even with a reminder call, but the truth is there are far less than without it. However you choose to deal with those patients who repetitively cancel, change, or break their appointments, it’s important to first follow up with a phone call for completeness of care. Document your call, their response, and reason for not showing, and their rescheduled date if they choose to make one. At every available opportunity stress the value of the time you are setting aside for them. It’s up to you to teach them. If you don’t, who will?
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FREE LIFE LABS

Interview with Founder and CEO, Benjamin Pogue

November is National Diabetes Month with World Diabetes Day on November 14th. Why is this important?
I don't think there is a person in the U.S. that isn't affected or know someone that is affected by diabetes. As a country, we need to continue to emphasize healthy eating and exercise. Most people understand that diabetes is bad, but do they understand exactly how it affects the body and the complications that can result from it? I think there needs to be more done educating people on the risks associated with the disease.

What is Nerve Reverse and where did the idea come from?
NerveReverse was created in response to both of my parents suffering from neuropathy. Both parents were put on medications (gabapentin) that gave them unwanted side effects. I knew there had to be a better way. Through hours of clinical research and development, NerveReverse was created to give neuropathy patients a safe, effective option that improves nerve health instead of only masking symptoms.

How does your product help podiatrists and their patients?
Our flagship product, NerveReverse, was created to improve peripheral neuropathy and it's associated symptoms. Most people have tried gabapentin/lyrica to help improve neuropathy symptoms. The challenge with these medications is that they do nothing to improve blood flow or restore nerve health. They also come with unwanted side effects.

This product is not covered by insurance but is reasonably-priced, especially when compared to some of the other options available. We give our podiatrists full control of how they want to run their business so it would be up to them if they want to offer discounts to their patients.

How does Nerve Reverse help?
NerveReverse is an all-natural supplement designed to improve blood flow to the nerves allowing them to become healthier, which reduces nagging symptoms such as numbness, burning, and tingling.

What other products does Free Life Labs offer?
We also offer other products such as a neuropathy pain cream, a nail supplement for fungal, weak, and brittle nails, and a urea-based lotion for dry, cracked feet.

How can patients obtain these products?
All of our products can either be sold by the physician out of their office or referred directly to us. Both options give the physician ancillary revenue for their practice. All products come with a money-back guarantee.

Where can podiatrists go to learn more?
If you are interested in our products, you may email us at support@freelifelabs.com, call us at 801-923-3878, or go to www.freelifelabs.com for more information.
**Featured TUSPM Students Class of 2025**

**JACOB STERN**
*TUSPM '25*

**Why did you want to pursue podiatry?**
“I want to pursue a career in podiatry due to its importance, versatility, and the work-life balance. There are a wide variety of locations a podiatrist can work and it feels limitless. I really think it’s incredible to have the ability to work in a hospital, a clinic, private practice, sports area, and so many other environments. I have had discussions with podiatrists about how they do have time outside of work to spend with their family and do the things they want; a luxury not all doctors have. Lastly, and most importantly, podiatrists are really at the center of such an important part of medicine. A wide variety of issues stem from our feet and podiatrists work hands on to help these situations.”

**What have you found most surprising during your first month of podiatry school?**
“The most surprising thing about the first month of podiatry school has been the support and kindness from all students, especially upperclassmen. During my undergraduate studies I felt that a lot of your own peers did not care whether you did well or not. At TUSPM, I have not felt that at all. I truly believe that everyone, fellow peers and faculty, want to see you succeed. The upperclassmen have been giving us such amazing advice and tips for certain courses and the best ways to study.”

**DARIA LAJOIE ZUCCI**
*TUSPM ‘25*

**Why did you want to pursue podiatry?**
“Podiatry was what I would describe as a “hidden gem” for me. I have wanted to be a surgeon for almost my entire life, but for years I was not sure what specialty was for me. I shadowed a wide variety of surgeons, and while their jobs were interesting, it never quite felt like a perfect match. I discovered podiatry in my graduate program and after shadowing podiatrists in a wound care and orthopedic setting, I fell in love and knew that the field I was meant to do had finally chosen me.”

**What have you found most surprising during your first month of podiatry school?**
“It may sound odd, but I was surprised by the dedication and encouraging nature of the professors. Like many other students in higher education, it can sometimes feel like the professors aren’t passionate about their jobs. I feel fortunate to have dedicated, passionate professors at TUSPM that genuinely care about my learning and my success. With the high volume of doctorate-level scientific material, it takes a load off of my shoulders to know that I can rely on the faculty.”

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PPMA extends a special thanks to Samantha Cooney, TUSPM ‘24, for these student interviews!
PA-PPAC Contributions

With every $100 Contribution to the PA-PPAC your name will be entered in a raffle at the end of the year to win a $500 Gift Card!

Philadelphia Division $1,000.00
Alicia Canzanese $15.68
Lackawanna Division $500.00
Central Division $150.00
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Lehigh Division $1,250.00

N Central Division $1,000.00
Mitchell Shikoff $50.52
Bradly Shollenberger $36.96
Delaware Division $750.00
Western Division $750.00

TOTAL: $6,008.16

Please note: Due to the delays in posting PA-PPAC contributor reports, it may take until the next issue to see your contribution.

MY COMMITMENT TO PENNSYLVANIA PPAC

To maintain and strengthen podiatry’s involvement on the state health care scene, I pledge my support to PA-PPAC’s 2021 Campaign. My voluntary political contribution of $_______ is enclosed.

Name__________________________________________________________
Address_____________________________________________________________________________
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Make check payable to PA PPAC. PERSONAL FUND CHECKS ONLY Contributions are not deductible for income tax purposes. You may contribute any amount or no amount without concern of being favored or disadvantaged.

Send to:
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The APMA Political Action Committee (APMAPAC) is a nonprofit, bipartisan fundraising committee through which member podiatrists and students support federal candidates who champion podiatric medicine’s issues before the US Congress.

**APMAPAC Contributions**

The APMA Political Action Committee (APMAPAC) is a nonprofit, bipartisan fundraising committee through which member podiatrists and students support federal candidates who champion podiatric medicine’s issues before the US Congress.

**TOTAL: $10,336.49**

**MY COMMITMENT TO APMAPAC - 2021**

Check here if this contribution is drawn on: ☐ 12-Corporate Account
Enclosed is my voluntary, personal political contribution of:

- ☐ $25 (Student)
- ☐ $75 (Young Physician)
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- ☐ $300
- ☐ $500
- ☐ $1,000
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- ☐ $5,000

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IMPORTANT: These are suggested amounts. You may contribute more, less, or not contribute without concern of being favored or disadvantaged. This information is required for contributions of $200 or more by the Federal Election Campaign Act. *Federal election law does not permit corporate contributions to be used for donation to candidates for federal office. Political contributions are not deductible for income tax purposes. Mail your contribution to: APMAPAC, 9312 Old Georgetown Road, Bethesda, MD, 20814

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PODIATRIST NEEDED PART- TIME PHILADELPHIA AREA: If you are interested in making extra income, I need help with doing house calls. Flexible hours. Please contact me at ssteven1818@gmail.com.

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PODIATRIST POSITION AVAILABLE: Multi- doctor, multi- office practice seeks a full-time Doctor of Podiatric Medicine trained in all aspects of podiatry and surgery. We currently have four doctors with four office locations around the Pittsburgh area. Qualifications:
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PRACTICE FOR SALE

SMALL PODIATRY PRACTICE FOR SALE IN SUNBURY PA: If interested, FAX to 570- 286- 8125.

PRACTICE FOR SALE PHILADELPHIA: Podiatry practice for sale; 7- figure gross revenue; multiple locations; very strong PCP referrals. Mainly conservative practice, but great potential with surgeries. Inquiries ONLY: 267- 970- 7647.

PRACTICE FOR SALE 20 MILES SOUTH OF PITTSBURGH: Successful, well- known, turn- key Podiatric Practice, operating 35+ years. Large, established patient volume. Multiple hospitals, surgery center, and wound care center nearby, providing great opportunity for surgically trained Podiatrist. Facility can support multiple doctors. Four well- equipped treatment rooms. HIPAA compliant billing/software with five stations. Very reasonable monthly rent with opportunity to purchase real estate. Email: happyfeet600@hotmail.com or call 724- 483- 5538.

FOR SALE: COMPLETELY EQUIPPED PODIATRIC PRACTICE: This solo podiatry practice is located in a beautiful suburban town close to the Pennsylvania turnpike and downtown Philadelphia. Annual revenue exceeds $200,000 with excellent referral base and volume. Additional amenities include an orthotic lab, digital X- ray, surgical suite, and plenty of free parking. Please send curriculum vitae and requests for pictures or a virtual tour of the office to: podiatry.mhersh1984@gmail.com.

PHILADELPHIA PRACTICE FOR SALE: Well Known podiatric practice, operating for 45+ years, established patient volume. Mainly conservative practice but great potential with surgeries. Can purchase office real estate. E-mail: drjjorlando@gmail.com or call (215) 487- 2222

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- 2 PDM Chairs;
- Excel X- Ray Unit;
- All Pro Tower with Tiger View 8 software. Best offer. Call 724- 853- 9896 and leave message. Serious inquires only.

- Podiatry equipment. Offices closing. Everything must go. 1 Ritter chair. 1 Midmark chair. 3 Contour chairs. Waiting room furniture. Copiers. 3 Custom SSS wall- hung, 4 drawer treatment room cabinets. 1 additional custom wall hung cabinet. Assorted file cabinets. All priced for quick liquidation. Pictures on request. Jeff. 717 615 9002. jmwitman63@gmail.com

CONTINUOUS

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Meet Morgan Baxter, DPM

What inspired you to pursue podiatry?
I shadowed a local podiatrist while I was in college and really enjoyed my experience with him. I also liked the idea that I could pursue a field that allows for a wide variety of options after residency to build or find a practice that can be tailored to my wants and likes.

What specialties do you focus on? Or what types of cases do you most enjoy?
I just started my first attending position and my first case was an ankle fracture! But I do a mix of everything from ingrown toenails in the office to infections and trauma. My favorite cases from residency would be ankle scopes and lateral ankle stabilizations!

What career goals are you working towards? Or what career milestones are you most proud of?
I was very fortunate to land my dream job in my hometown. I work in an orthopedic group and am currently the only podiatrist in the practice. My goals include traveling the world, building my dream home and getting involved in the podiatry community either at the local or state level.

How has technology impacted your podiatry practice?
I am on Instagram (@monvalleyfootandankle) and I hope I can connect to other like-minded physicians to continue to learn new techniques or approaches to surgery. I would also like to help educate the general population about our profession because I think there is still a large gap of what it means to be a podiatrist in this day and age.

What is something that you learned recently that's helped you professionally?
Just reiterating that taking time with my patients can do wonders for their trust in you and hopefully a referral in the future. I just had a patient today thank me for taking the time to listen to their problems. She felt comfortable with me because I listened to her problems without her feeling rushed or unheard.

What advice do you have for podiatry students?
Learn as much as you can and do the best you can. All your hard work will pay off. If you are interested in a specific part of the country you would want to do your residency in, it is never too early to reach out to those programs and try and visit. Be consistent with your follow-ups if you are interested in that program.

Diabetes is a ‘pandemic of unprecedented magnitude,’ and experts fear Covid-19 may make it worse
By Sandee LaMotte, CNN

The year 2021 marks 100 years since the discovery of insulin, a game-changing drug in the fight against diabetes.

Despite a century of advancements in treatment, education and prevention, World Diabetes Day 2021 occurs in the wake of grim statistics. One in 10 adults around the world -- some 537 million people -- are currently living with diabetes, according to figures recently released by the International Diabetes Federation (IDF).

By 2024, the IDF predicted that the number of people with diabetes is expected to rise to 1 in 8 adults.

“As the world marks the centenary of the discovery of insulin, I wish we could say we’ve stopped the rising tide of diabetes,” IDF President Dr. Andrew Boulton told CNN. “Instead, diabetes is currently a pandemic of unprecedented magnitude.”

Read full article [here](#).
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PPMA/APMA DUES PAYMENT REMINDER:
Cut-off date for end-of year dues payments is December 15, 2021.

*The Board has waived the first quarter of dues for the 2020/2021 for renewing members in response to the financial hardship visited upon the membership by the COVID-19 virus.

Remember to place your PPMA Member Number or full name on check if remittance stub not sent back with payment. Don’t forget to PAY ONLINE to assure payment is received on time!!!

Because APMA and PPMA engage in certain restricted lobbying activities, 5% of your National Dues and 10% of your State Dues are not deductible as an ordinary and necessary business expense, if otherwise deductible.

If you are having a problem paying your dues, please contact Jenna Clay at 717-763-7665, Ext. 213, or email Jenna@ppma.org to discuss possible payment options that may be available to you.
Upcoming Events

26th Annual FAPA Seminar in the Sun
FEBRUARY 19-22, 2022
Iberostar Paraiso Maya and Grand Resort, Riviera Maya, Mexico
16 CECH

72nd Annual Region Three Meeting
MAY 4-7, 2022
Harrah’s Atlantic City Hotel and Casino, Atlantic City, NJ
25 CECH

17th Annual Montana Meeting
SEPTEMBER 7-10, 2022
Doubletree Missoula-Edgewater, Missoula, MT
12 CECH

50th Annual Clinical Conference
NOVEMBER 3-6, 2022
Valley Forge Casino Resort, King of Prussia, PA
26.75 CECH

Annapolis Meeting
DECEMBER 2-4, 2022
Historic Inns of Annapolis, Annapolis, MD
12 CECH

PPMA Installs New Officers

Laura Virtue-Delayo, DPM, practitioner in Scranton, PA, was installed on November 13, 2021 as the new President of the Pennsylvania Podiatric Medical Association (PPMA) during its House of Delegates Banquet at The Sheraton, Harrisburg, PA.

The rest of the officers are as follows:

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- Laura Virtue-Delayo, DPM
  - President-Elect
- E. Douglas Hutson, DPM
  - Vice President
- John A. Mattiacci, DPM
  - Secretary
- Mark E. Pinker, DPM
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- Sabrina Minhas, DPM
  - Immediate Past-President

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samantha.cooney@temple.edu

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