Dynamic Chiropractic

ORTHOTICS & ORTHOPEADICS

Conscientious Care

Rayfield Aranow

With our professional concern for the overall well-being of our patients many of us presume, unconsciously perhaps, there will be an automatic reward ratio of a better than average living. Thankfully, that is often so. But we are all subject to human frailties and tend to overcompensate for our shortcomings. Some extend into areas where we are not adequately equipped to tread. One such relatively recent bandwagon is footcare for the primary purpose to purvey "orthotics." (The correct term is orthoses.)

There is growing recognition that postural distortions of the foot can lead to back pain, extending even unto the cervicals (and commonly at that). The conscientious chiropractor who, recognizing his ignorance in a highly specialized field, seeks the cooperation of a podiatrist. It's no different than an referral to an OBGYN of a woman with a genetically defective uterus who wants children. Most postural foot defects are also gene-induced, and have complex effects.

The mere fact that the foot factor is part of (or cause) of a kinetic chain problem in which our care excels, does not necessarily impart to us the knowledge (or moral right) to treat a condition at the core of an entirely separate field of training devoted to the lower extremity. How can we presume to have expertise even remotely approaching the specified training of the DPM to that limited portion of the anatomy? Would even careful following of the "erudite" on the subject in our profession, or even in the podiatry field for that matter, impart to us anything more than, at best, an academic basis for some understanding?

In following the simplistic recommendations of the purveyors and hucksters, and armed with the rationalization that literature and lectures have conferred adequate knowledge, some patients may be helped (to an extent). The partial or temporary relief then confirms the justification for the approach. Would we, on the same basis, accept the adequacy of those in other professions who have learned to apply some manipulative (even adjustive) procedures, seemingly successfully, to some patients? Or does our shoe fit and theirs not?

I hope to open eyes that want to see, in heads and hearts that want to care, because I care for both my professions, podiatry and chiropractic. Having been trained in both, having practiced both together for roundly half a century, I believe I have a basis for some authority. In fact, I do not know who has more of a basis. So I am distressed by indiscriminate use of orthoses dispensed with inadequate examination and diagnosis, to say nothing of knowledge. I fear possible backfiring and the consequences at a time when chiropractic is at a crossroads, especially in the face of managed care. (In a suit happy environment that fear is compounded.)

How many are aware of:

- the pes planus that is normal, versus the signs telling it is not?

- the relationship between the forefoot and rearfoot to determine where the best post and by how much, no less how to measure that relationship?

- what functional capacity of the hallux may determine whether an orthotic or accommodative approach is indicated?

- how to take functional foot x-ray views so crucial to diagnosis, and possibly ruling out an orthotic device?

- even how to read the films?

- how to do a gait analysis, and the necessary well lit minimum 20 foot run space in the office to do a barely adequate one? (No, the treadmill does not work, because that gait is unnatural). I found a distinct difference when I was able to take a patient to the street. In one case of a world class marathoner it made the crucial refinement possible for his performance.

- And, most importantly, how many use the necessary instrumentation for measurements critical to the optimal posting any true orthotic device requires? All inserts are not orthotic by a long shot. And I am only scratching the surface.

Functional casting is essential to critical control. Control is the keyword. The majority of cases require limitation of excessive motion, primarily in hyperpronation. Accurate casting is not easy, even in the expert hands of the podiatric specialist. So casting foam is eschewed in such cases and generally reserved for the simpler situations, such as for accommodative appliances. These are usually for the softer variety providing mainly cushioning, as for a geriatric arthritic or older diabetic for whom little else may be advisable. But first it must be clearly established that only an accommodative is best indicated. If so, this is an area open to conscientious chiropractic care, in which even more can be done by way of taking the rest of the individual into account in a manner others cannot do as we can.

Even for the foot device, orthotic or accommodative, there is at least one other facet to consider: the foot gear. That does not even take into account: current varieties of materials; their varying applications; degrees of hardness and purpose; and the myriad variations in corrective or accommodative controlling substances and shapes, either ready-made or custom ordered.

Footgear, by the way, includes sock or stocking. That recommendation depends not only on skin type and sensitivity factors, but also circulation (or lack thereof), climate, work or use and, not the least item on the part of some, appearance. Is hyperhidrosis present, for instance? Is there a fungus infection?

Is it acute, chronic or intermittent? What about corns or calluses, hypertrophic or ingrowing nails as incidental factors requiring possible modifications, even for some sock or stockings as to size or material?

As for the shoe, what type, and for what purpose? Are you going to use the same device for walker, runner, marathoner, truck driver, model, housewife, child, to fit in any shoe for any purpose and with any heel height? How do you make the marriage between foot type, shoe last and the appliance: straight last; inflare; outflare; combination; toe box; seam placement; lace; buckles; velcro; or slip-on? How about construction: Goodyear welt, McKay Stretchdown, or slip-lasted in

conventional street shoes? In running, jogging, aerobic or athletic shoes of specialized needs, what to select, dear colleagues, especially with the continual changes in each brand alone? The day of the perennially staple sports shoe is gone.

Particularly for an orthotic device, to fit it only to the foot, which requires some expertise in itself, without taking the footgear into the process, borders on criminal neglect to me. The foot, sock and shoe must mate harmoniously for a proper outcome. This is a time-consuming task for the non-expert and can lead to headaches, figuratively and literally. In a few instances I have gone to the shoe store on my time off with a particularly difficult case or frustrated patient. For my turn of mind it was worth it and paid off in referrals, but it is not what I would suggest as a usual routine. But each to his own.

Once the rule outs are done by the podiatrist on the patient referred by the DC, the same attitude on the part of the DPM will establish a mutually productive working relationship. The podiatrist will refer patients to the DC for care of the structures above the lower extremity. Moreover, the DPM will learn to have the DC check out those factors in the spine and pelvis that are affecting lower extremity function.

In our centennial year we have long since grown out of our adolescence to rightfully assume our full-fledged place in the healing arts. Such a level of professionalism recognizes it is impossible to know all there is to know, even in one's own field.

One does not hesitate to refer to others of greater expertise. That is what I plead for. The symbiosis of referrals works to the benefit of all concerned, and certainly to the one who needs it most: the patient.

Rayfield Aronow, MA, DPM, DC
Sebastapol, California

NOVEMBER 1996

©2024 Dynanamic Chiropractic™ All Rights Reserved