SPRING 2022
Vol 87 No 1

THE SMAE INSTITUTE™

THE JOURNAL OF

Podiatric Medicine

For the Private Practitioner

How to read and appraise a paper

PAGE 12

Aging - Theories and Fall-Out

Part III - Body Changes Associated with Getting Older

PAGE 38

The use of homeopathy in the treatment of hallux abducto valgus and bunion deformities

A systematised review of the application of pseudo-crem

PAGE 28

PLUS

All Regular Features!

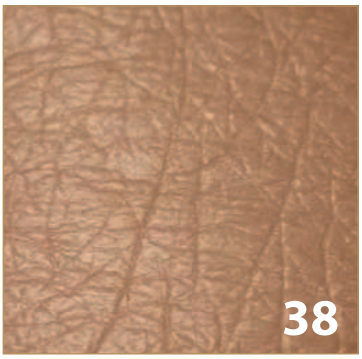
What's inside…

TRAINING TO EXCELLENCE 103 YEARS THE SMAE INSTITUTE

PROUD PAST, EXCITING FUTURE

Available by Subscription **ISSN 1463-4325**

Contents



THE SMAE INSTITUTE™

The Journal of
Podiatric Medicine

Managing Editor:
Michael J. Batt

Editorial Committee:
Nicola Batt
Joint Principal

Dr Derek Kayanja
MBChB, MSc, MPhil, PgCert (L&T)

Jemma Wilson
BA (Hons) LM, PG Cert (ODE), Cert Mgmt, Cert Bus Stud, MInstLM

Andrew Hill
MSc Podiatry; BSc (Hons); PGCert L&T; FFPM RCPS(Glasg); FHEA; FSSCh; MB-CPA; HCPC Registered

Tracey O'Keeffe
MA (Education), BSc (Critical Care), RN, MAFHP, MCFHP

Contact Details:
For advertising information contact our advertising manager on:

T: 01628 621100
E: COBrien@smaeinstitute.co.uk

Editorial Address:
The SMAE Institute
The Journal of Podiatric Medicine
The New Hall
149 Bath Road
Maidenhead
Berkshire SL6 4LA

Design & Print:
MB Creative
www.wearembcreative.com

follow us
@Smae_Institute

Editorial

THE SMAE INSTITUTE™

Unbelievably we are now in the fourth month of 2022, and we hope it is being kind to you all so far. Spring is upon us, with the evenings slowly getting lighter. Talking of new beginnings, both Nicky and I will be writing the editorial as Joint Principals from now on.

Did you remember the clocks went forward on Sunday 27th March 2022? Thankfully most clocks use technology today, but we did miss a couple of wall clocks in the office this year!

Did you know Benjamin Franklin first proposed the idea of daylight savings in 1784 in a letter he wrote whilst in Paris? However, William Willett was the man who introduced the idea of Daylight-Saving Time in Britain in 1907 (who happens to be Coldplay singer Chris Martin's great-great-grandfather). Willett published a leaflet called 'The Waste of Daylight' encouraging people to get out of bed earlier by moving the clocks backwards and forwards by 80 minutes (20 minutes for four Sundays in April and September). It is believed he wanted to change the law to allow for more light in the evenings as it interrupted his golf games. The idea was discussed in Government in 1908, but many were not taken by the idea. Willett spent his life campaigning the idea, however he died of influenza in March 1915. In the Spring of 1916, during World War One, the German army turned the clocks forward as a way of conserving energy. It was then that many (not all) European governments followed shortly afterwards, including the UK. Back then the hands on many clocks could not be turned back without breaking the mechanism, and so instead they had to move the clock forward by 11 hours when summer time came to an end.

So, now back to clinicial practice. It has been brought to our attention that some practitioners think they can avoid using autoclaves to sterilise their instruments. Autoclaving is the only method that is fully approved, other methods are not approved because there is no guarantee they destroy all infections. So please remember you could invalidate your insurance by using chemical sterilisation. It is not an approved method and you will be very unwise in utilising it, so do be careful and ensure that you autoclave all your instruments. The autoclaves, some of which are quite small, can be used in the evening when you finish your surgeries. If you are in doubt about anything, always check with us.

On a further note we have all been looking forward to the return of our Annual Convention and Summer School this year. As we write this we are just getting ready to head off to the Annual Convention in Thame, Oxfordshire and we hope everyone enjoys it as much as we do. Our next exciting event is the Summer School, which as you will know has had to be postponed due to circumstances beyond our control. This will now be called "Summer School in the Fall" and will be held on 7th and 8th October 2022 at the Holiday Inn in High Wycombe.

We very much look forward to seeing you again in person. When you attend our events do ensure you pop over and say hello to us both, its lovely to catch up with everyone.

Mike Batt
Joint Principal

Nicky Batt
Joint Principal

Did you know that changes were made to The Highway Code on Saturday 29th January 2022? There are 8 changes that you should be aware of and can be found here: ***https://www.gov.uk/government/news/the-highway-code-8-changes-you-need-to-know-from-29-january-2022***

Submission of articles

Content of submitted articles should be Podiatry or Foot Health related.
Please ensure you include your full name, post nominals and a photo of yourself.

Please include references to any books or papers mentioned in your article.

THE SMAE INSTITUTE

COVID-19

UPDATE ON GUIDANCE

As of March/April 2022, the UK Government have moved to 'living with COVID' and all legal restrictions have ended. In addition, testing requirements have been lifted and free access to lateral flow tests (LFTs) has also ended. This means that rapid, self-testing is not so readily accessible and those who wish to keep routine testing will need to pay to do so unless they have specific exemptions on the basis of health or particular vulnerability. Some health professionals may be able to procure free LFTs but they will need to check directly with Gov.uk. Given some regional difference in rules around face covering and the like, it is always important to check with your own local authorities about the specifics of the guidance and rules.

At this point, you should all be able to see any patient in your caseload requiring treatment and it is advised that you work in a careful and cautious way that seeks to help your patients feel safe and well cared for. The following rules still apply but they may change in the months ahead as the UK Government consider changing rules around self-isolation. We will provide an update if and when this happens.

- *If you feel unwell, have a high temperature, a loss of taste or smell and/or a new continuous cough, you should presume that you may have COVID-19 and should refrain from treating any patients until you have recovered. If you do get access to testing and you test positive, you may return to work after negative LFTs on days 5 and 6 or on day 10 if you feel well but are still testing positive.*
- *If your patient has had a case of COVID-19 confirmed, there is to be no service provided for a minimum of 10 days (or 6 if they have 2 negative lateral flow test results on days 5 and 6)*
- *If you provide services to a residential home, you MUST liaise with the home to ensure that you can work within their plans and policies that are in place to protect their residents*
- *In all other circumstances, you are fine to proceed, but you MUST maintain good infection control practices*

The other main consideration that you will need to have at this time relates to safe working practices. This includes both the working environment and personal protective equipment (PPE). In accordance with this need, we are issuing the following advice in conjunction with advice from Public Health England (links here: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe and https://www.gov.uk/government/publications/covid-19-how-to-work-safely-in-domiciliary-care).

In essence the general advice is along the following lines:

- *Whilst it is no longer essential to pre-screen all patients to gauge the seriousness of their foot complaint – you may wish to continue to phone ahead in order to check that the patient is happy for treatment to go ahead*
- *Ensure that you employ the strictest infection control practices and have adequate PPE*

PPE Guidelines:

- *You will be required to use surgical gloves that are disposed of after every treatment and/or after they have become damaged or visibly soiled with bodily fluids (as is usual practice)*
- *Hand-washing has to be thorough and rigorous before donning PPE and immediately after removing PPE*
- *DO NOT touch your face at any point whilst wearing PPE or once it is removed until you have thoroughly washed your hands*
- *FFP2 or FFP3 masks would be optimal BUT surgical face masks are appropriate where treating a patient. Surgical face masks are to be disposed of after every appointment. FFP2 or FFP3 masks may be reused up to 3 times if they have not become damaged or soiled AND/OR where you have not been in close contact with the face or upper-respiratory tract of a person with suspected (or confirmed) COVID-19.*
- *Patients should be offered to wear a surgical face mask for the duration of their contact with you and they can dispose of them following their contact with you. However, this should not be routinely considered to be a condition of treatment and people who are exempt from wearing face coverings are not obligated to provide proof of their exemption*
- *A face shield / visor OR eye protection is optional*
- *Regular aprons will suffice*

All of the PPE items listed above should be available through Podiacare. Please note that due to local, national and global supply and demand issues it may not be possible for Podiacare to supply all items on that list immediately but they are working very hard to make sure that they can, so do please keep contacting Podiacare with your orders.

If you have any queries, please do not hesitate to contact us and please do continue to keep safe and well.

THE SMAE INSTITUTE™

FRIDAY 7TH & SATURDAY 8TH OCTOBER 2022

Summer SCHOOL IN THE FALL




"If you think education is expensive, try estimating the cost of ignorance."

Howard Gardner

Win!

All delegates are automatically entered into the prize draw with great prizes up for grabs

1st Prize - **£100 Podiacare voucher**
2nd Prize - **Free Online CPD**
(one subject of your choice)

Join us at this popular event to enjoy exclusive access to the extensive trade exhibition and listen to eminent lecturers who will enhance your knowledge, all alongside a delicious hot/ cold buffet lunch and unlimited refreshments.

For booking information
Visit www.smae.co.uk, call Jane Rhodes on 01628 560654 or email JRhodes@smaeinstitute.co.uk

AGENDA SUMMER SCHOOL IN THE FALL OCTOBER 2022

Friday 7th October

8.30am – 9.20am Registration & Trade Stands

9.20am – 9.30am Introductory Welcome

9.30am – 10.30am ***Raymond Robinson*** *MSc, BSc, BMedSci, PgCHEP, Course Director Podiatry, Ulster University*

Pulsed radiofrequency energy (PRFE) – a little known gem in the armoury of physical therapies for MSK management?

Radiofrequency energy treatment has been used for some decades in the management of musculoskeletal (MSK) pain. More recently, devices have become miniaturised, portable and available in the UK as an over-the-counter (OTC) 'topical' analgesic for localized MSK pain and injury (ActiPatch® BioElectronics Corporation, MD, USA).

As an acute muscle pain treatment, the ActiPatch device has been demonstrated to significantly reduce postoperative pain and the requirement for narcotic pain medications in submuscular breast augmentation patients. In two chronic musculoskeletal pain conditions, plantar fasciitis and osteoarthritis of the knee, the device was also found to significantly reduce pain and medication use.

This talk will review the efficacy, safety and cost effectiveness of this form of physical therapy to assist practitioners in decision making on the use of this treatment for their patients.

10.30am – 11.15am Tea/Coffee Break – Trade Stands

11.15am – 12.15pm ***Robert Isaacs*** *Bsc.pod.M. M.Ch.S, HCPC Registered Podiatrist*

Beyond Bunions, a beginners guide to 1st MPJ pathology

The 1st MPJ is a very busy joint. It has a lot of jobs to do during gait, and can suffer from a variety of very different problems, requiring a variety of very different treatment approaches. In this talk, we will look at some of the common complaints which patients will come to you with, and some simple, straightforward conservative treatment approaches.

12.15pm – 1.30pm Lunch Break (Buffet) – Trade Stands

12.40pm – 1.25pm Practical Breakout Session (Optional) £12pp

Neurological assessment workshop with Andrew Hill

Many FHPs and Podiatrists are used to undertaking 10g monofilament and tuning fork assessments but there are a plethora of neurological assessments that can be performed on the lower limb. This practical breakout session is designed to give you a demonstration of a comprehensive neurological examination of the foot with a test-by-test explanation of the individual examinations being performed. This workshop aims to refresh your knowledge of neurological assessment of the lower limb and provide you with the confidence to improve this aspect of your clinical practice.

1.30pm – 2.30pm ***Belinda Longhurst*** *Podiatrist / Lecturer (BSc (Hons) MCPod, HCPC Registered Podiatrist, Member of the British Dermatological Nursing Group)*

The Good (benign), The Bad (pre-malignant) and The Ugly (Malignant) Skin Lesions

This lecture will cover diagnosis, treatment, when and where to refer skin tumours of the lower limb and assist practitioners in formulating appropriate referral pathways.

2.30pm – 3.00pm Tea/Coffee Break – Trade Stands

3.00pm – 4.00pm ***Andrew Hill*** *MSc Podiatry, BSc (Hons), PGCert L&T, MSSCh, MBChA, FHEA, HCPC Registered, Clinical Services Manager of The SMAE Institute*

Sticks and stones…the nocebic power of words

Words have the power to 'elevate or destroy'. Language is powerful and can have a strong impact on perceptions, behaviour and experiences. Language is the principle vehicle for sharing of knowledge and understanding. Words are immediately shaped into meanings when people hear or read them and those meanings can affect how a person views him- or herself. In 2017, psychiatrist Arthur Barsky wrote an article entitled "The iatrogenic potential of the physician's words" which has had an impact at continuing to understand the concept of nocebo and nocebic language (Barsky, 2017). The article is extremely useful at shining a light on how communication with patients can affect the outcome (and expected outcome) of medical treatment. It is this notion of the potentially (and almost always unintentionally) detrimental impact of the choice of words or turn of phrase the clinician uses that will be the topic of this lecture. Recognising how this may present in the world of Podiatry and foot health and how we can become ever more reflective in practice to try and reduce our own potential of using nocebic language in our clinical encounters with patients.

Saturday 8th October

8.30am – 9.20am Registration & Trade Stands

9.20am – 9.30am Introductory Welcome

9.30am – 10.30am ***Jonathan Brocklehurst*** *MRCpod, BSc (Hons), ARSM, HCPC Registered Podiatrist*

The international impact of fungal infections on the foot.

Mycetoma is a chronic infection in the skin and is classically defined as a 'tropical disease'. This talk will look to discuss what Mycetoma might tell us about neglected diseases; how climate change may play a role in fungal foot infections; the role of foot health education in preventing disease; how we, as practitioners, can address diseases affecting the feet and the Global Action For Fungal Infections.

10.30am – 11.15am Tea/Coffee Break – Trade Stands

11.15am – 12.15pm ***Peter Allton*** *MCPod DPodM Clinical Director - Circle Podiatry, CEO of Undefeeted CIC, Author of Undefeeted by Diabetes*

Should education play a bigger part in preventing Diabetic foot complications and amputations?

The aim of the lecture is to inspire and motivate practitioners to take raising awareness to the next level, giving them tools to help build into their practices robust down to earth methods of educating their patients on how to keep their feet healthy for life especially whilst living with Diabetes.

Including an introduction to Undefeeted's SATNAV Diabetic foot risk assessment tool.

12.15pm – 1.30pm Lunch Break (Buffet) – Trade Stands

12.40pm – 1.25pm Practical Breakout Session (Optional) £12pp

Vascular Assessment with Andrew Hill

A vascular assessment is a crucial aspect of Podiatric and FHP practice. This practical session will guide you through the practicalities of basic vascular assessment as well as a consideration of use of Doppler and interpreting Doppler sounds. Ideal for the newly qualified, as well as those looking for a refresher. All materials/equipment supplied.

1.30pm – 2.30pm ***Deborah Rockell*** *Podiatrist / Lecturer DipPodMed; MSSCh*

What's in a shoe?

E (Education) - Footwear Advice. This lecture will discuss the features to look for and discuss with your patients, to help treat their foot problems.

2.30pm – 3.00pm Tea/Coffee Break – Trade Stands

3.00pm – 4.00pm ***Tracey O'Keeffe*** *MA, BSc, RN, PGCE, MCFHP MAFHP, Part-time Tutor/Lecturer at The SMAE Institute*

On My Lonesome…

As foot health clinicians, we often work alone rather than surrounded by work colleagues. This is more evident in domiciliary care where we enter people's own homes. This lecture will consider some of the risks associated with this and it will explore strategies to keep us safe - personally, professionally and clinically.

The SMAE Institute reserves the right to alter the agenda if necessary. It cannot be held responsible for events outside of its control. Please always check for updates on our website www.smaeinstitute.co.uk/events - Summer School 2022

Meet Our Lecturers

Peter Allton

MCPod DPodM, Clinical Director - Circle Podiatry, CEO of Undefeeted CIC, Author of Undefeeted by Diabetes

Peter has run a successful private podiatry business, Circle Podiatry, for over 18 years now, having been practicing in the NHS for some 13 years previously. Peter has always pursued excellence to ensure that his patients receive the best of treatment outcomes and has led his team to win no fewer than 9 business awards since 2008, including the best business for Customer service in London at the FSB London awards 2017. He was awarded the College of Podiatry's Meritous award for services to the profession.

Peter's passion for helping people with diabetes stems from 3 sources: more than 30 years' experience as a Podiatrist dealing with the devastating effects of the disease on people's feet: his personal battle with Type 2 diabetes and his experience with his daughter's diagnosis with type 1. He and his wife Tina founded the multi award winning not for profit organisation Undefeeted, whose mission is to help people with diabetes prevent foot complications and amputations by helping them live as safely as possible with their disease. Peter is the author of Undefeeted by Diabetes. He walks his talk having successfully reversed his Type 2 diabetes and remains off all his meds 3 years on.

He also presents 2 weekly radio shows on UK Health Radio – The Diabetes Show and The Foot Health Show and writes 2 regular columns for the Health Triangle Magazine – The Diabetes Sweet Spot and Foot Notes.

Andrew Hill

MSc Podiatry, BSc (Hons), PGCert L&T, MSSCh, MBChA, FHEA, HCPC Registered, Clinical Services Manager of The SMAE Institute

Andrew graduated from the University of Brighton in 2006 with a BSc (Hons) in Podiatry. He has worked as a Podiatrist in both the NHS and Private sector – both in the UK and Australia. Since 2008 he has worked at The SMAE Institute as an educator ascending to the role of Clinical Services Manager and Programme lead in 2012. In addition to his post graduate teaching qualification in higher education, Andrew obtained his MSc in Podiatry from QMU in 2015 and is currently undertaking his professional doctorate at the University of Bath looking specifically at the barriers and facilitators to good foot self-care behaviours in people with diabetes. Diabetes is a core area of professional interest for Andrew and he has publications within peer-reviewed journals on patient education and self-care in diabetes. In 2018 Andrew was made a Fellow of the British Chiropody and Podiatry Association and in 2019 Andrew became a Fellow of the Faculty of Podiatric Medicine within the Royal College of Physicians and Surgeons of Glasgow where he has recently been appointed as a regional advisor for Podiatry within London. Andrew's key professional goal is to help develop and drive high quality of training and education at levels within the foot health & Podiatry sector, which in turn can lead to recognition for all levels of clinician in foot health and ultimately help to best serve the public. Andrew's current roles involve his educational lead on the SMAE's FHP; Diploma in Higher Education (Podiatry Assistant); Local Anaesthesia and Prescription Only Medicines courses. He also maintains private practice work, is a peer-reviewer for Patient Education and Counselling and The Diabetic Foot Journals. Andrew also works as an education visitor for the Health and Care Professions council.

Summer SCHOOL IN THE FALL

Friday 7th October
Saturday 8th October

Robert Isaacs

Bsc.pod.M. M.Ch.S, HCPC Registered Podiatrist

Robert is a podiatrist in full time clinic practice, both within the NHS and private practice. He has held a specialist post in biomechanics for 15 years and has lectured internationally on biomechanics and MSK podiatry.

Belinda Longhurst

Podiatrist / Lecturer BSc (Hons), HCPC registered podiatrist, MCPod

Belinda graduated from the University of Southampton, where she was awarded a first-class BSc (Hons) degree in Podiatry, with a distinction in clinical practice and has worked as a private practitioner from 2003 until 2017. She is a Trustee and volunteer coordinator for the registered charity Forgotten Feet, which offers free footcare to the homeless and socially isolated. As a post graduate student at QMU Edinburgh, she continues to research in her area of special interest: podiatric dermatology - and has frequently presented her published work at both national and international conferences.

Tracey O'Keeffe

MA, BSc, RN, PGCE, MCFHP MAFHP, Part-time Tutor/Lecturer at The SMAE Institute

Tracey qualified as a nurse in 1992 and her career has taken her through many different specialities including intensive care, neurology and cardiac before working in the community as a Rapid Response Nurse. She has also been a Senior Lecturer teaching nursing in university and currently works as an Education Facilitator for Primary Care. Tracey is Smae trained and has her own private practice. She is a part-time Tutor for the Smae Institute FHP Diploma, Diploma in Higher Education (Podiatry Assistant); Local Anaesthesia and Prescription Only Medicines courses.

Raymond Robinson

Clinical Lecturer, BSc BSc Hons PgCert MSc

Raymond has been a Clinical Lecturer in Podiatry since 2004 and is a Fellow of the Higher Education Academy. He graduated with a BSc in Genetics and Microbiology from Queens University (QUB) in 1990 and a BSc Hons in Podiatric Medicine in 1998 from QUB. He has a PgCert in HE Practice from Ulster (2007) and PgCerts in Steroid and Silicone Injection Therapy (2010).

He completed his MSc (Distinction) in Podiatric Medicine from QMU/GCU in 2014. His main areas of teaching and interest include anatomy, biomechanics, injection and physical therapies. Raymond works in clinical practice and is currently undertaking a PhD by publication.

Deborah Rockell

Podiatrist / Lecturer DipPodMed; MSSCh

Deborah is a Podiatrist who qualified at The SMAE Institute in 2002 following a distinguished career in the Police force. Since 2002, Deborah has worked in private practice both in the UK and Dubai and as a clinical tutor at The SMAE Institute.

Jonathan Brocklehurst

MRCpod, BSc (Hons), ARSM, HCPC Registered Podiatrist

Jonathan is a Podiatrist, clinical tutor at The SMAE Institute, former NHS Diabetes Specialist Podiatrist, and Presenter on UK Health Radio's Foot Health Show. His career has recently spanned to writing, most recently for Wounds UK Journal on wound care ethics. His interests have also broadened to Dermatology, with Mycetoma of particular note.

Practitioner of the Year Award 2021

By Jemma Wilson
BA (Hons) LM, PG Cert (ODE), Cert Mgmt, Cert Bus Stud, MInstLM, General Manager of The Smae Institute

FROM ENTERING THE CLINIC TO LEAVING TRISH MADE ME FEEL VERY COMFORTABLE WITH THE "COVID PROCEDURES" IN PLACE AND BY HER FRIENDLY MANNER.

SHE HAS CONSISTENTLY GIVEN EXCELLENT CARE AND SERVICE - EVEN THROUGH THE WORST OF THE PANDEMIC.

IN MY VIEW SHE IS A CREDIT TO HER PROFESSION

Many of our Members go above and beyond the call of duty and so 2012 saw the introduction of our award for "Practitioner of the Year" to enable us to recognise those who do so.

Over the last twelve months we have been inundated with nominations from patients and fellow practitioners for a variety of Members, based not only on the superb care that they offer and their passion for their work, but also for their contribution to their local community and the profession. Based on the number of nominations received, we are delighted to announce the Winner and Runners-Up of the "Practitioner of the Year 2021".

Winner
PRACTITIONER OF THE YEAR 2021

Trish Parker
MCFHP MAFHP

Trish, in Essex, joined The SMAE Institute as a Member in 2006 after qualifying as a Foot Health Professional and was previously awarded Practitioner of the Year in 2019. Trish received the largest number of praising nominations detailing her caring character, hard work and professionalism from her gratified patients.

Here is just a snippet of comments received from Trish's grateful patients alongside their nominations:

"Her treatments are relaxing and refreshing and my feet feel as if they are walking on air! Her clinic is very comfortable and welcoming." J.Tyne

"I have been attending her foot clinic regularly for many years. She is always pleasant and welcoming, as well as being an efficient and competent" P.Turnbull

"From entering the clinic to leaving Trish made me feel very comfortable with the "Covid procedures" in place and by her friendly manner. I must say the all-round experience, end result and manner in which Trish went about the treatment were a breath of fresh air and I have nothing but appreciation for her. I will have no hesitation in recommending Trish to friends and family as I am currently free from pain and comfortable walking again." M.Scarrott

"She cares for my feet on a regular basis and at each visit she is always cheerful, friendly and moreover extremely professional. She has taken so much care of her customers throughout the Covid difficulties, providing excellent protection for them during treatment. First class" A.Smith

"Trish is wonderful. Caring and attentive always happy to go a little further to make sure her clients have what is needed in their foot care." D.Chivers

"She is always helpful in explaining things about my feet; I always feel good about my feet when I leave her clinic. My feet always feel free of pain. She is friendly & we always have a good laugh while putting world to rights" C.Stoker

"My rather demanding feet feel refreshed and comfortable following her care. In my view she is a credit to her profession." P.Weston

" She has consistently given excellent care and service - even through the worst of the pandemic. She is always so helpful, caring, efficient and pleasant. Trish is a credit to her profession. I always look forward to having my feet treated by her." D.Cassell

"She always gives me a warm and friendly welcome when I go to see her. I have long term diabetic problems and MS and since she has been treating my feet they are in great shape and I can walk on them a lot better than I could. The pain level is also improved. " B.Unger

Trish says "Why should I be Practitioner of the Year? I'm not sure that I am more worthy of the honour than anyone else that has been nominated. It has been a tough few years for our profession and anyone who has worked through it is just as deserving.

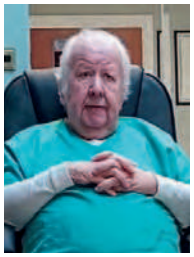
The way we work has had to change to include social distancing and extra protection for ourselves and our customers while still keeping an informal atmosphere and personal service, not an easy thing to achieve, however I feel I have managed to keep my clients and myself safe and still keep that personal rapport.

It would have been easy to close my doors and stop practicing during the pandemic, but I am passionate about my work and feel I have an obligation to my patients who in many cases would have had trouble getting the treatment they need or just needed someone to talk to.

Does this make me worthy of this award? Thinking about it, yes, it probably does".

As the winner of "Practitioner of the Year 2021" Trish receives a complimentary place at one of our eagerly anticipated events (either the Summer School or Annual Convention), as well as a Practitioner of the Year Trophy and certificate detailing her award. **Congratulations Trish!**

Joint Runners-Up



Derek Harland

FSSCh DipPodMed MBChA

Derek, in Surrey, joined The SMAE Institute as a Member in 1988 after qualifying as Chiropodist. Derek received a number of praising comments, including this from a fellow practitioner:

"Derek was one of my early mentors, when I was a very green podiatrist. The fact that he, as a grandparented podiatrist, had so much to teach me, as a degree trained podiatrist, did much to erode the animosity which had been inculcated into me toward the "others". His clinical skills were beyond reproach, but more importantly, he demonstrated a level of care and compassion for his patients which I have never seen surpassed, before or since.

This was someone who saw a challenging case as a person in need of help, and who would move heaven and earth to find them a solution. Regularly he would call me several days after we'd seen someone to pick over an idea he may have had. Often more than once. I never saw him give up on anyone, no matter how difficult the case or personal challenge.

As a mentor, Derek has moulded me more than any other podiatrist. He has been a constant support when I've had personal or professional difficulties, and supported me throughout the career. I know he has done the same for many other fhps and podiatrists." R.Isaacs

Derek says "I was surprised and happy to be nominated for Practitioner of the year. Since I qualified with the SMAE in 1988 I have worked to a very simple rule. The patient welfare comes first, always. This simple ethos has driven me to work continuously on my skills, completing numerous courses in things like Cryotherapy, local anaesthesia and biomechanics. It has also motivated me to form close working relationships with other professionals who can further enhance the services I can offer. I believe that this patient focus is the key to a successful, fulfilling and lucrative practice".

THE SMAE INSTITUTE™

SINCE I QUALIFIED WITH THE SMAE IN 1988 I HAVE WORKED TO A VERY SIMPLE RULE. THE PATIENT WELFARE COMES FIRST, ALWAYS.

Sarah Harknett

MCFHP MAFHP

Sarah, in Kent, joined The SMAE Institute as a Member in 2019 after qualifying as a Foot Health Professional. Sarah received many compliments, with this particularly praising recommendation:

"She's an incredible individual. Not only is she friendly, caring and kind person. She always goes the extra mile. For example, she has helped no end with supporting a customer of hers I know of who has recently been diagnosed with MS. She is diligent and works so hard. She has many happy customers and her customer numbers have grown through word-of-mouth recommendation and even though she gets busier and busier, whenever she treats her customers they are her number one priority and she always completes the job to a very high standard, she is exemplary. She is always trying to better herself and researching conditions and has created referral pathways to more advanced practitioners. She thoroughly deserves recognition for all of her hard work she is a credit to your organisation." J.Shapter

Sarah says " I am incredibly passionate about people and foot health care and being able to care for and relieve their discomfort or pain in a relatively short period of time is very fulfilling. I am very aware that many people I attend to are housebound and vulnerable. I enjoy spending time with them and giving them a 'window' as to what is going on outside in their local community. I invest time, patience and try to introduce laughter and happiness during my visit so not only do their feet feel great at the end of their visit their hearts and heads do too.

I strive to be the best version of me and by undertaking regular training and continued professional development I want to be able to offer the best treatments to my patients through the changing and progressing evidence-based medicine and research available to them.

I am also very passionate about educating people and helping people have as much information as they can to make informed choices."

BY UNDERTAKING REGULAR TRAINING AND CONTINUED PROFESSIONAL DEVELOPMENT I WANT TO BE ABLE TO OFFER THE BEST TREATMENTS TO MY PATIENTS

As joint runners-up of "Practitioner of the Year 2021", Derek and Sarah both receive a complimentary CPD subject of their choice from either our Workshop or CPD@Home range.
Congratulations Derek and Sarah!

How to read and appraise a paper

By Andrew Hill
DHealth Candidate (University of Bath); MSc Podiatry; PGCert L&T; FFPM RCPS(Glasg); FHEA; FSSCh
Programme Lead and Senior Lecturer – BSc (Hons) Podiatry, The SMAE Institue

Over the past couple of years the term "Follow the Science" has been uttered in perpetuity. Whilst the phrasing is somewhat effective as a soundbite, it is meaningless in actuality as science is a method, not an end-point or destination. It does not lead, it does not follow – it is quite simply a means to try and understand phenomena as robustly as possible. Furthermore, it should be incumbent upon every person to engage in critical thought sufficiently so that they, themselves, can appraise the evidence to the best of their abilities and not defer such responsibility onto others. Whilst it is quite true that an expert appraisal of the existent evidence is likely to be more considered and deeper than that of a relatively lay-person, that does not mean that the latter will not have valid and important conclusions or that the former has a monopoly on being 'correct'. Indeed, 'appeal to authority' is, itself, a logical fallacy that all should be wary of falling foul of. If, therefore, it is incumbent upon individuals to engage in critical thinking and seek to appraise the evidence for themselves, it is crucial that people are well-enough equipped to do that. Whilst imperfect, the evidence that we have for whatever subject it is we are exploring is usually what exists in the body of peer-reviewed literature for that subject. For those not familiar and well-versed in reading such literature, it can be a difficult task to identify high-quality evidence from much poorer quality. The aim of this article, therefore, is to provide something of a precis to how to read and appraise an academic paper.

THIS GUIDANCE ARTICLE IS APPROPRIATE FOR SOMEONE WHO HAS NO BACKGROUND WHATSOEVER IN SCIENCE OR MEDICINE

De-Mystifying the landscape

Whether pandemics, drug and treatment interventions, climate change or other forms of modelling, getting science wrong has very real consequences. But journal articles, a primary way science is communicated in academia, are a different format to newspaper articles or blogs and require a level of skill and undoubtedly a greater amount of patience. One early thing to wrestle with is 'what constitutes scientific authority?' This is not just a trivial debate. Policy decision often hinge upon the advice of such authorities and policy decisions can and do have extremely serious consequences. What constitutes enough proof? Obviously everyone has a different answer to that question, but to form a truly educated opinion on a scientific subject, one needs to become familiar with current research in that field. This requires them to have read the primary research literature. This can be a laborious and frustrating process – especially when faced with conflicting perspectives and 'evidence'. Thus, it often requires a means of understanding what sits behind the headline statements or conclusions to try and get a sense of where the most robust evidence is pointing.

This guidance article is appropriate for someone who has no background whatsoever in science or medicine, and based on the assumption that he or she is doing this for the purpose of getting a basic understanding of a paper and deciding whether or not it's a reputable study. The main types of scientific papers out there are primary research articles and review articles. Primary research articles are peer-reviewed reports of new research on a specific question. Review articles are also peer-reviewed, and do not present new information, but summarise multiple primary research articles, to give a sense of the consensus, debates, and unanswered questions within a field.

Preliminary Steps

Reading a scientific paper is a completely different process than reading an article about science in a blog or newspaper. Not only may it be necessary to read the sections in a different order to how they are presented, but it is also important to take notes, read it multiple times, and probably look up other papers for some of the details. Reading a single paper may take a very long time at first. Be patient with it, however. The process will go much faster with experience. Most papers will be divided into the following sections: Abstract, Introduction, Methods, Results, and Conclusions/Interpretations/Discussion. The order will depend on which journal it's published in. Some journals have additional files which contain important details of the research, but are published online instead of in the article itself.

Notes:

Prior to reading the article, it is important to first take note of the authors and their institutional affiliations. Some institutions (e.g. University of Oxford) are well-respected; others may appear to be legitimate research institutions but are actually agenda-driven. You may have to search out institutions you are unfamiliar with to check their credentials. It is also important to take note of the journal in which it is published. Reputable journals will be identifiable through major journal databases and may well have a published journal impact factor (IF). The IF is scientometric index calculus that reflects the yearly mean number of citations of articles published in the last two years in a given journal. As a journal-level metric, it is frequently used as a proxy for the relative importance of a journal within its field. Journals with higher impact factor values are given status of being more important, or carry more prestige in their respective fields, than those with lower values.

Finally, one should be prepared as they read an article to write down every single word that they do not understand. They will need to be looked up and understood as scientific writing requires extremely precise wording to convey very precise meaning. There is no substitute for understanding the exact meaning of a given sentence or statement within a paper.

Step-by-step Instructions

Table 1 (below) outlines the key steps that ought to be taken when reading a paper. These are expanded upon in this section of the article:

Step 1	Read the introduction (not the abstract)
Step 2	Identify the main question being asked
Step 3	Summarise the background premise of the question in no more than 5 sentences
Step 4	Identify specific questions the paper is asking
Step 5	Identify the approach to obtaining the answer to the question(s)
Step 6	Read and summarise the methods used
Step 7	Summarise the results / findings
Step 8	Do the results answer the specific question(s)?
Step 9	Read the conclusion / discussion / interpretation section
Step 10	Now read the abstract
Step 11	What do other scientists think of this paper?

Table 1 - Key Steps

How to read and appraise a paper

A HYPOTHESIS (PLURAL HYPOTHESES) IS A PROPOSED EXPLANATION FOR A PHENOMENON

Step 1

Begin by reading the introduction, not the abstract. The abstract is that dense first paragraph at the very beginning of a paper. In fact, that is often the only part of a paper that many non-scientists read when they're trying to build a scientific argument. This is not good practice. Abstracts are useful (along with the title) for trying to decide if a paper that has been retrieved from a search is relevant to the area of interest, but when the paper is to be read fully, it is always helpful to read the abstract last. This is because abstracts contain a succinct summary of the entire paper, and this can cause the reader to inadvertently becoming biased by the authors' interpretation of the results.

Step 2

Identify the main question being asked. This is separate from: "What is this paper about". Instead, it is more a case of: "What problem is this entire field trying to solve?" This helps you focus on why this research is being done. This might help to identify some evidence of agenda-motivated research.

Step 3

Summarize the background in five sentences or less. Some useful questions to guide this step may be:

- What work has been done before in this field to answer the main question?
- What are the limitations of that work?
- What, according to the authors, needs to be done next?

The five sentences part is a somewhat arbitrary, but it forces the reader to be concise and really think about the context of this research. One needs to be able to explain why this research has been done in order to understand it.

Step 4

Identify the specific question(s). What exactly are the authors trying to answer with their research? There may be multiple questions, or just one. It is helpful to identify them by writing them down. If it is the kind of research that tests one or more null hypotheses, it then becomes important to identify it/them. A hypothesis (plural hypotheses) is a proposed explanation for a phenomenon. For a hypothesis to be a scientific hypothesis, the scientific method requires that one can test it. Scientists generally base scientific hypotheses on previous observations that cannot satisfactorily be explained with the available scientific theories. Even though the words "hypothesis" and "theory" are often used synonymously, a scientific hypothesis is not the same as a scientific theory. A working hypothesis is a provisionally accepted hypothesis proposed for further research in a process beginning with an educated guess or thought. By contrast, the null hypothesis is essentially the alternative hypothesis. For example, if the hypothesis is that compound A increases the potency of effect B, the null hypothesis would be that compound A has no effect on the potency of effect B. In this way, in inferential statistics, the null hypothesis is that the observed difference is due to chance alone. Research papers with a hypothesis have to first disprove the null hypothesis before they can begin to seek to prove the hypothesis. It is important to note, however, that not all such papers will present a null hypothesis.

Step 5

Identify the approach. What are the authors going to do to answer the specific question(s)? This should become evident from the end of the introductory segment of the paper and be clearly articulated within the methods/methodology section.

Step 6

This is arguably the most important step in many respects. Reading the methods section. It may be helpful to draw a diagram for each experiment, showing exactly what the authors did including as much detail as needed to fully understand the work. The methods do not necessarily need to be understood in enough detail to replicate the experiment—that is something that peer-reviewers have to do—but one is not ready to move on to the results until they are able to explain the basics of the methods to someone else. It is within this section that the understanding of exactly how and why the study was conducted in the way that it was to answer the question(s) from steps 2 and 4. It is at the point that major limitations of the paper may start to become evident. If understanding the methods results in questions being raised about the robustness of the study, it is good practice to write them down at this point.

Step 7

Read the results section. It is helpful to write one or more paragraphs summarising the results for each experiment, each figure, and each table. It is not so important at this stage to worry about what the results mean, just what they are. Typically, in particularly in good papers, the majority of the results are summarised in the figures and tables. These require close scrutiny too – the devil is often in the detail! Sometimes, one may need to go to the Supplementary Online Information file to find some of the results.

It is at this point where difficulties can arise if statistical tests are employed in the paper and one does not have enough of a background to understand them. This article is not focused on understanding statistics. However, to really develop deep comprehension of quantitative studies, then taking the time to understand the fundamentals of statistical analysis is important.

Particular things to pay attention to in the results section:

- Any time the words "significant" or "non-significant" are used. These have precise statistical meanings relating to whether or not the results are likely the signal of a real effect (significant) or may just be the result of change (non-significant). It does not mean that the results are necessarily important. That is a different understanding of the word significant in a different context.
- If there are graphs, do they have error bars on them? For certain types of studies, a lack of confidence intervals is a major red flag.
- The sample size. Has the study been conducted on 10, or 10,000 people? (For some research purposes, a sample size of 10 is sufficient, but for most studies larger is better).

Step 8

Do the results answer the specific question(s)? What do you think they mean?

It is important not to move on until this has been thoroughly considered. It is acceptable for one to change their mind in light of the authors' interpretation—in fact most readers probably will, especially if inexperienced in analysis—but it is a really good habit to start forming one's own interpretations before reading those of others.

Step 9

Read the conclusion/discussion/Interpretation section. Is it valid? Does the conclusion provide a direct answer to the question(s) that the paper was seeking to answer?

What do the authors think the results mean? Are they logical and well-reasoned? Do you agree? Is there a valid, alternative way of interpreting them? Do the authors identify any weaknesses in their own study? Do you see any that the authors missed? What do they propose to do as a next step? Does that seem appropriate / reasonable?

Step 10

Now, go back to the beginning and read the abstract. Does it match what the authors said in the paper? Does it fit with your interpretation of the paper? Does it provide a valid and accurate portrayal of the study and its findings?

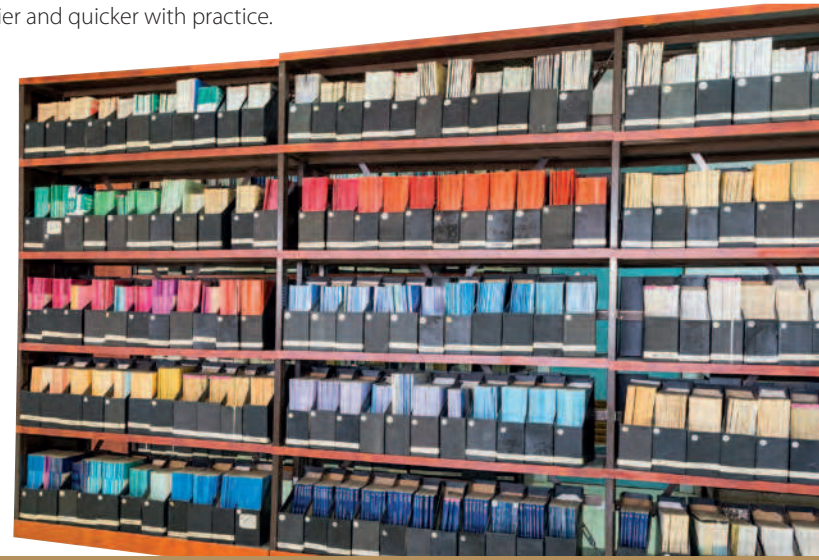
Step 11

Final Step: What do other researchers say about this paper?

Who are the acknowledged experts in this particular field? Do they have criticisms of the study? Are they criticisms that you have not identified? Do they generally support the findings from this paper?

Whilst these steps may provide some challenges for those unfamiliar with reading academic papers, it is hoped that this article does provide something of a practical tool to help make the process a little more organised and less confusing. It is an involved process – understanding does not come following a perfunctory approach to the relevant literature. However, it is a process that does get easier and quicker with practice.

IT IS A REALLY GOOD HABIT TO START FORMING ONE'S OWN INTERPRETATIONS BEFORE READING THOSE OF OTHERS



HILARY SUPPLIES
34A Halstead Rd, Mountsorrel,
Loughborough, Leicester LE12 7HF
Telephone: (0116) 230 1900

Product Information

Out of Mykored Spray evolves Mykored Deodorant

In the past we have received concerns that the Mykored Spray has caused throat irritations. This has urged Lutticke to modify the Spray and redefine a better differentiation between the Mykored Lotion in the pipette bottles and Mykored Deodorant.

The new Mykored Deodorant is available in the familiar black 70ml Spray bottles and also the 500ml Professional size. The effectiveness of the new product is equal to the previous one. The deodorising effect is improved by using an innovative active ingredient. The preventative active ingredients against fungal infections are no longer achieved through a combination of salicylic acid, benzoic acid, bromchlorophene and Undecylenamide-DEA, but instead using clotrimazole. We have already seen successful results using clotrimazole in the other Mykored products, Mykored Nail Protection Oil and Mykored Forte Cream.

The new product is available now from all the usual suppliers. As the new Mykored Deodorant is still so effective but more pleasant to use, we are sure your customers will be happy with the improvements.

The ingredients in Mykored Lotion in the pipette bottles remain the same as before.

MEMBER OF
THE SMAE INSTITUTE

Smae Members Shield

Have you requested the Members Shield? Get yours now and show you are a valid Member!

This Shield is designed to underline only those with this emblem are current practicing Members of The SMAE Institute and its associated professional association(s).

All other shields, logos and images relating to The SMAE Institute, and/or its professional associations have been discontinued and should not be used. These have now been superseded by the Members Shield.

You can request a copy of the shield by emailing Carol O'Brien at **cobrien@smaeinstitute.co.uk**. Remember to include your Membership Number in the communication.

Medical Emergency Procedures Courses

As you are aware, Medical Emergency Procedures Courses are valid for 3 years, at which point Practitioners are required to undertake a refresher course.

To ensure our records are up to date, please ensure we receive a copy of any recently completed first aid course certificates that you may have for inclusion on your file. If you have a current certificate, please email a copy to Karen Cooper (Membership Department) at **kcooper@smaeinstitute.co.uk** for her to update your records.

If you would like to book a place on our popular Medical Emergency Procedures Course with Tracey O'Keeffe, you will find a copy of the Booking Form enclosed with this Journal. Simply return the form to Gill Hawkins at **ghawkins@smaeinstitute.co.uk** or via the postal address detailed on the form.

New dates now available - see page 48

Diploma in Local Anaesthesia

www.smae-la.co.uk

The timetable for the 2022 Diploma is as follows:

Open / Registration Day (Location: The SMAE Institute)
Saturday 19th February 2022
This was a pre-requisite for those who wish to enrol

Introductory Lectures (Location: The SMAE Institute)
Friday 20th May 2022

Module 1 (Location: e-Learning)
Begins: Monday 23th May 2022

Module 1 Assessment Submission
Friday 19th August 2022

Module 2 (Location: e-Learning)
Begins: Monday 26th September 2022

Module 2 Assessment Submission
Friday 9th December 2022

Clinical Practice
February 2023

The **Open Day for the 2022 Cohort** was held on Saturday 19th February 2022. If you are interested and would like to attend the 2023 Open Day please contact Gill Hawkins at **ghawkins@smaeinstitute.co.uk** . More information about this Diploma can be found at **www.smae-la.co.uk**

Please note: Those wishing to enrol onto this course must provide evidence of registration with the HCPC.

*** Instalment Option Available**

Diploma in Prescription Only Medicines

www.smae-poms.co.uk

Our next cohort begins December 2022. More information about the 2022 cohort can be found at www.smae-poms.co.uk

Open / Registration Day (Location: The SMAE Institute)
Saturday 5th November 2022
This is a pre-requisite for those who wish to enrol

Introductory Lectures (Location: The SMAE Institute)
Friday 25th November 2022

Module 1 (Location: e-Learning)
Begins: Monday 28th November 2022

Module 1 Assessment Submission
Monday 3rd April 2023

Examination (Location: The SMAE Institute)
May 2023 (tbc)

If you are interested in the 2022 POMs Cohort, please contact Gill Hawkins at **ghawkins@smaeinstitute.co.uk** for more information and to book yourself a place on the upcoming Open/Registration Day.

Please note: Those wishing to enrol onto this course must provide evidence of registration with the HCPC and demonstrate annotation in LA on the HCPC Register.

*** Instalment Option Available**

hcpc health & care professions council

hcpc health & care professions council

Connect with us

To keep in touch and up-to-date on our latest developments, follow us on social media. You can:

Tweet us @The_HCPC
Follow us on www.linkedin.com
Find us on www.facebook.com/hcpcuk
Watch us on www.youtube.com/user/HCPCuk
Visit our website on www.hcpc-uk.org

Notes:

Council welcomes three new members

The HCPC announced the appointment of Dr Rebekah Eglinton, Prof Steven Vaughan and Prof Valerie Webster to the Council.

Dr Rebekah Eglinton is a Clinical Psychologist specialising in child protection and psychological impacts of trauma. Rebekah has nearly 20 years' experience in mental health settings and public protection, working across a range of service contexts. She is currently the Chief Psychologist to the Independent Inquiry into Child Sexual Abuse and Head of the Inquiry's Support and Safeguarding Teams.

Prof Steven Vaughan is Vice Dean of UCL's Faculty of Laws where he holds the Chair in Law and Professional Ethics. A regulatory and governance specialist, his research covers a wide range of areas, from environmental law to diversity to legal education to lawyers' ethics and professionalism.

Prof Valerie Webster is a registered Physiotherapist and Fellow of the Chartered Society of Physiotherapy. She has over 28 years' experience in higher education and recently retired as Deputy Vice-Chancellor (Learning, Teaching & Student Experience) at Glasgow Caledonian University.

Read more about these new members here: **www.hcpc-uk.org/about-us/who-we-are/council/council-members/**

HCPC launches EDI data factsheets for professions

The HCPC is aiming to be recognised as an organisation that actively upholds and promotes best practice in equality, diversity and inclusion (EDI). Improving the quantity and quality of our diversity data is an important step towards achieving this aim.

Between December 2020 and March 2021, we collected diversity data from 51,000 registrants across the 15 health and care professions we regulate in a voluntary survey. This represents 18% of the HCPC Register and a three-fold increase in responses as compared with our 2019/20 survey.

We have used this data to create individual profession factsheets, which can be found on the HCPC website. These factsheets break down the key EDI information by profession and show how the demographics of each group compare to the demographics of HCPC registrants overall.

You can also read the full report here. **www.hcpc-uk.org/resources/reports/2021/diversity-data-report-2021/**

Understanding the Duty of Candour - new resources available

The HCPC has launched new online materials on the Duty of Candour, which aim to support professionals' understanding of what candour means and what it looks like in practice.

All professionals we regulate have a Duty of Candour, which is essentially a responsibility to be open and honest when things go wrong. This requirement is also reflected in Standard 8 of our Standards of conduct, performance and ethics.

Being candid has many proven benefits. For example, being open and honest when things go wrong can help encourage a more positive working culture which is focused on learning and support, rather than blame. Not only does this support professional practice and development, but it can also improve patient care by helping to mitigate the risk of the same error recurring.

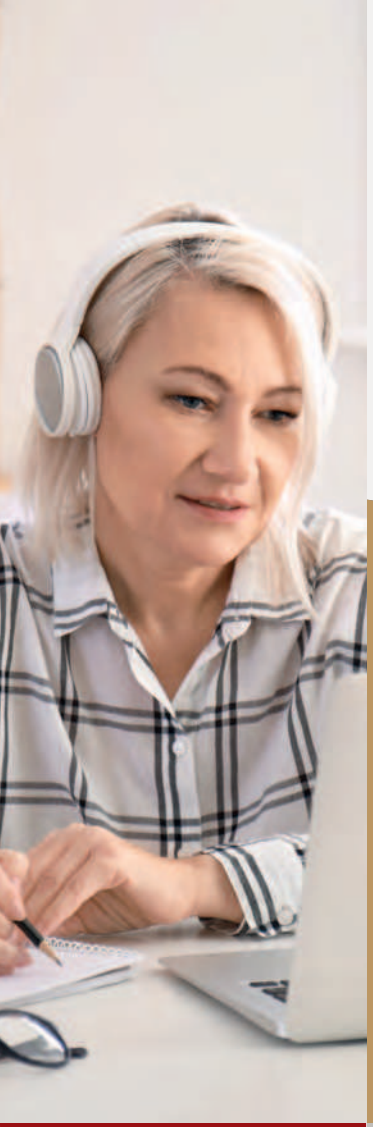
The Duty of Candour applies to all health and care professionals, which means that these resources may also be useful for non-HCPC registrants. We also encourage employers to use them to help embed transparency into their teams.

You can access the Duty of Candour online resources here. **www.hcpc-uk.org/standards/meeting-our-standards/raising-concerns-openness-and-honesty/the-duty-of-candour/**

Latest updates from HCPC Chair Christine Elliott

Read the latest blogs from our Chair for updates of how HCPC are working to reach the key decisions and initiatives.

Find out about the latest updates about the revised health and character guidance, our fitness to practise improvement programme, regulatory reform, the HCPC professional liaison service and much more on the HCPC website.



THE SMAE INSTITUTE™

BSc (Hons) PODIATRY

About the course

The SMAE Institute, in collaboration with Queen Margaret University (QMU), is proud to introduce this four-year distance based, blended elearning BSc (Hons) Podiatry course. On this course you'll gain the knowledge, practical skills and confidence that you'll need to practise as a registered podiatrist in the private sector or NHS.

This is a four-year, distance learning honours degree, at levels 7-10 on the Scottish Credit Qualification Framework (SCQF), that is designed to enable those who have successfully completed the SMAE Institute Diploma in Foot Health, which is credit rated by QMU, to progress to eligibility to apply for HCPC Registration.

Course Overview

Duration: 4 years distance learning

Start Date: September 2022

Format: Distance based, blended elearning

Fees: £3,999 per year (payment options available)

Awarding Body: QMU

Queen Margaret University
EDINBURGH
Collaborative Partner

This course will not only develop you to the standard required for eligibility to apply for HCPC registration, but will also give you the skills, attributes, clinical experience, plus personal and professional confidence to be at the forefront of the profession and to become the future influencers, managers and leaders of the profession. This course aims to develop a podiatrist who is a patient focused practitioner, reflective in all aspects of practice, and proactively engaged with learning and professional development to enhance and advance both their individual practice and their profession.

Course Structure

This course is delivered via blended e-learning, which means as a student you would be working at a distance via the internet (utilising a Virtual Learning Environment (VLE)) as well as attending lectures, practical and clinical sessions at The SMAE Institute. In addition to this, students will also attend placements in the private and third sector. Whilst most content is delivered online, lecturers will guide you through your learning and provide one-on-one and small group support throughout. Each year students will be required to attend clinical training and/or placements, and schedules.

Teaching, learning and assessment

This is a distance-based, blended e-learning course that requires dedicated hours of study commensurate with full-time learning. Each module has dedicated weekly live tutor chat sessions with the designated module leader (tutor), who is also available via personal email and telephone at scheduled times. There is also administrative support staff available online and via telephone daily. The module forums are accessible for each module to provide a virtual classroom environment and will be accessed and supported by staff and tutors alike. The assessment method varies from module to module and the majority of the course will be distance learning with some compulsory attendance. The dates of attendance required are given to students at the beginning of the course so that they can plan ahead.

Whilst The SMAE Institute is the organisation delivering your study, on this course you will be also be a student of Queen Margaret University (QMU). As such you'll be given access to their learning resources and have a QMU VLE (virtual learning environment) username and password.

Course Modules

YEAR ONE

Module Name	Module Description
Manual Handling	This module is designed to provide the student with the knowledge and skills required to develop an analytical, reflective and professional approach to implementing safe manual handling.
Clinical Studies 1	This module is designed to enable the student to acquire the knowledge and skills necessary to investigate, diagnose and manage a range of common lower limb pathologies seen in low risk patients.
Locomotory Science and Anatomy – The Foot and Ankle	This module introduces the student to the mechanical principles that underpin gait analysis and explores in detail the structural anatomy of the lower limb, with particular emphasis on the ankle and foot.
Locomotory Science and Anatomy 2 – Normal Gait	This module explores in detail the structural anatomy of the lower limb, with particular emphasis on the leg, knee and thigh as well as the gait cycle and normal developmental variants.

YEAR ONE

Module Name	Module Description
Cell Biology, Physiology and Microbiology	This module enables students to develop an understanding of the role of Podiatry and other health disciplines in the context of cell biology, physiology and microbiology. There is a focus on the structure, function and neuro-humoral regulation of the endocrine system, and its relationship to other major physiological systems as well as developing knowledge and understanding of microbial growth and survival emphasising features relevant to interactions with humans and human health.
Evidence Based Healthcare - Sourcing and selecting literature to understand and inform research	This module develops student understanding of the use of research in evidence-based health care delivery; through guided exploration of the ways in which research informs development and implementation of guidelines for clinical practice.

YEAR TWO

Module Name	Module Description
Clinical Studies 2a	This module enables a student to develop an understanding of the underlying principles of pharmacological therapy and the rationale for treatment relating to the cardiovascular, autonomic and inflammatory response. It also develops a student's theoretical knowledge and practical skills required to administer digital local analgesia (POM-A as per HCPC annotation).
Clinical Studies 2b	This module enables the student to investigate and diagnose a range of pathologies related to soft tissue and structural anomalies, and consider and demonstrate appropriate therapeutic regimes including the use of functional foot orthoses.
Pathophysiology	This module provides knowledge and understanding of the pathological processes relating to the systems covered in human physiology. It will introduce students to the concept of problem-based medicine and provide deeper understanding of physiological processes and the application to the clinical context. This module will also focus on the role of Podiatry within the broader context of multi-disciplinary care in managing patients with chronic and / or complex pathology.
Disorders and Management – Musculoskeletal conditions	The module provides the student with the necessary skills and knowledge base to diagnose and carry out effective management strategies for musculoskeletal conditions affecting the lower limb.

YEAR TWO

Professional Issues – Part 1 - Professionalism	This module prepares the student for registered practice as a Podiatrist by enabling them to critically examine and interpret the elements of professionalism within the contexts of delivering healthcare and podiatric practice. This will be considered against the backdrop of Interprofessional working,

YEAR THREE

Module Name	Module Description
Clinical Studies 3	This module develops students skills in examination, evaluation and management of the 'high risk' lower limb by developing high level psychomotor skills and by developing skills to undertake evidence based podiatric practice (in particular developing familiarity with NICE and SIGN guidelines). This module also enables students to gain experience of utilising POM-A in using digital block analgesia, and undertaking nail surgery procedures.
Locomotory Science and Anatomy 3 – The hip, pelvis, nerve supply and pathological gait	This module explores the structural anatomy of the lower limb with particular emphasis on the hip, pelvis and the motor & cutaneous nerve supply to the lower limb and helps students to develop a knowledge base and the skills required to distinguish between normal gait changes across the life cycle and pathological gait.
Disorders and Management 3	This module helps the student to develop a deep knowledge and understanding of the physical and psychosocial manifestation of systemic diseases related to Podiatric practice in association with relevant podiatric, pharmacological and surgical management through a problem based and shared learning approach. It further enables the student to critically analyse their own and other health professionals' roles, expertise and perspectives in healthcare practice in the context of lower limb pathology as well as service users' perspectives on self-care
Disorders and Management 3 – Dermatology of the lower limb	This module provides consideration of the differential diagnosis, potential impact and management of cutaneous and systemic disorders and diseases on the skin of the lower limb. It further enables the student to critically analyse their own and others' roles, expertise and perspectives in healthcare practice in the context of lower limb dermatology
Evidence-based Healthcare – Appraising the Evidence	This module enables students to develop their understanding of the importance of appraising evidence and helps them to develop their ability to constructively appraise evidence and to construct a focussed literature review.

YEAR FOUR

Module Name	Module Description
Clinical Studies 4	This module enables the student to fulfil the requirements for eligibility for HCPC registration by consolidating skills in examination, evaluation and management of the 'high risk' lower limb, to enable evidence-based practice. This module further helps the student to develop experience of new patient triage and referral, utilising POMS-S, psychomotor skills such as needling techniques, and anaesthetic techniques such as tibial block.
Disorders and Management 4 – Tissue Viability	This module enables the students to critically investigate/ study the evidence base for factors contributing to cutaneous ulceration, and the effectiveness of current management practices. It further enables the students to critically analyse their own and other health professionals' roles, expertise and perspectives in healthcare practice in the context of cutaneous ulceration.
Evidence-based healthcare – Clinical Audit	This module engages students in decision-making in the context of quality assurance, user perspectives, priorities of service delivery and practice development.
Developing Electronic Resources for Patient Education	This module enables the students to explore a topic of interest relating to patient education in Podiatry presented through electronic media for public broadcast.
Podiatric Mechanics (Elective)	This module enables the student to evaluate and apply current concepts in podiatric mechanics in the management of foot and lower limb pathology with particular reference to podiatric surgical intervention.
Medicine and Pathology (Elective)	This module enables the student to critically appreciate the clinical principles, philosophy and concepts which underpin critically relevant medical conditions and associated pathological changes in the foot.
Professional Issues – Preparation for Registration and Practice	This module provides an opportunity for students to critically consider the skills and attributes required to become an autonomous, HCPC registered private practitioner in the context of inter-professional collaborative working

Facilities / Placements

You'll consolidate your theoretical learning by working directly with patients during clinical sessions undertaken mainly at the SMAE Institute's purpose built clinic in Maidenhead, Berkshire. Some observational placements will be undertaken within specialist private practices and observational and practical placements will be undertaken in a third sector charity organisation. Academic staff will arrange and co-ordinate your placements, with the aim to be as local to the individual as possible. Where attendance is required, you will be informed of the dates at the beginning of the academic year to enable you to plan ahead.

A summary of clinical/placement attendance is detailed below, however please note that these time-frames are not specifically week blocks of time, but will be spread out across the academic year at a range of placement providers. Full details and dates are given to students at the start of the academic year.

Year One: Two weeks clinical/practical attendance

Year Two: Two weeks clinical/practical attendance

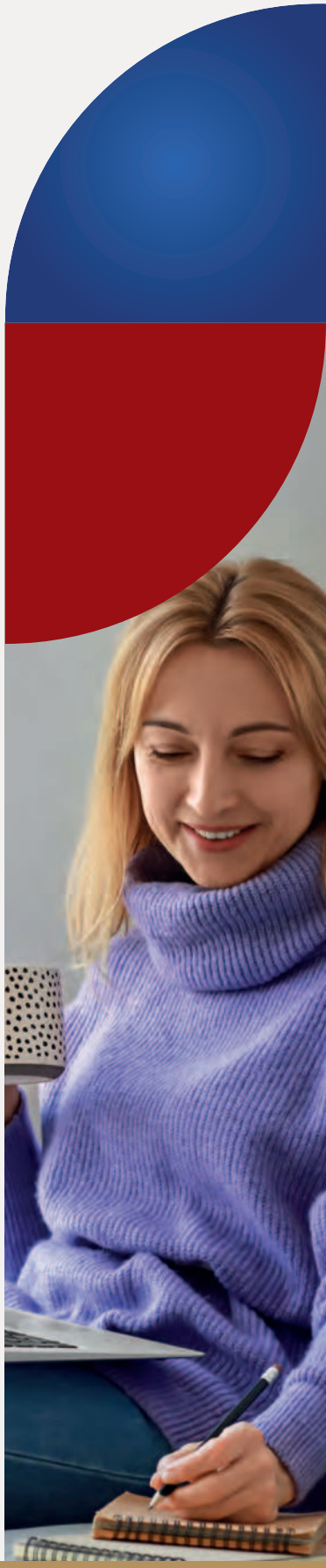
Year Three: Five weeks clinical/practical attendance

Year Four: Six weeks clinical/practical attendance

Qualification / Exit points

Successful completion of all four years will give you the award of BSc (Hons) Podiatry and eligibility to apply for HCPC registration.

In certain circumstances, a student may exit the course after completion of Year One with the award of Certificate in Higher Education (120 credits), Year Two with a Diploma in Higher Education (Assistant Practitioner – Podiatry) (240 credits) or Year Three with the award of BSc Health Studies (480 credits). Please note that by exiting the course in Year One, Two or Three, one is not eligible to register with the HCPC, only upon successful completion of Year Four and award of BSc (Hons) Podiatry entitles one to register.



Entry requirements

- The applicant has normally, within the last 5 years, completed one of the following:
  - successfully completed the SMAE Institute 60 credit diploma in foot health,
  - successfully completed the Diploma in Higher Education (Assistant Practitioner – Podiatry),
  - successfully completed the first year of a BSc (Hons) Podiatry at another University,
  - successfully completed a Foot Health course that can be mapped to the SMAE Institute's Diploma in Foot Health.
- The applicant has a current DBS certificate.
- The applicant has an up to date CPD portfolio (has attended at least one CPD event in the last 12 months and in addition can demonstrate ongoing professional development, for example, reading journal articles and applying them to practice)
- The applicant has up to date vaccination against Hep B, has had a recent eye sight test, and are encouraged to declare any disabilities (physical, mental or learning).
- The applicant has provided a suitable character reference (where the applicant is previously unknown to The SMAE Institute)
- If English is a second language the applicant has achieved an IELTS English equivalency level 6 or above (scoring above 5.5 in each section) (successful completion of the access courses outlined above would satisfy this).

Fees and funding

The course fees for this programme will be £3,999 per academic year.

Payment options (per academic year)

- A deposit of £424.00 followed by 11 monthly payments of £325.00 (0% Interest)
- A deposit of £710.00 followed by 11 monthly payments of £299.00 (0% Interest)
- One off payment (£3,999.00 per academic year)
- Sponsor (details of your sponsor would be requested)

What's included?

You may have to pay additional costs during your studies. A summary of the costs that you may be expected to pay, and what is included in your fees, while studying this course are listed here:

- DBS checks, where required, are included in the course fees.
- Access to learning resources through the virtual learning environment and the QMU library is included.
- Instruments used in clinical placements are provided by the establishment.
- Where your course includes a placement, travel costs are not included in the course fees.
- Insurance for your clinical practical placements is included.
- Clinical clothing, where required, is not included in the course fees. However, any relevant PPE will be provided to the student at placement sites.

Professional registration

This course is approved by the Health and Care Professions Council (HCPC). Successful completion enables application for registration with the Health and Care Professions Council as a Podiatrist.

Awarding body

Queen Margaret University
EDINBURGH
Collaborative Partner

Open day and admissions

If you are interested in studying this course, please contact Jane Rhodes at The SMAE Institute (degree@smaeinstitute.co.uk) who will initially send you an application form to complete to ensure eligibility. This application form will provide pre-screening questions outlining the admission criteria (set out above). If you meet the entry criteria, The SMAE Institute shall then invite you to an open day followed by an informal interview. The interview panel will consist of one of the programme co-leads, the quality assurance manager and a service user (patient). All members of the interview panel pre-agree the questions that will be asked before the interview takes place. The interview process shall consist of cross-checking the pre-screened applications to see that prospective students do indeed meet the correct entry criteria.

Following the interview the SMAE Institute shall select appropriately qualified students for offer of admission as students of the Institute/University and formally offer them a place. Should you be unable to travel to the SMAE Institute for an interview then you may be offered an online virtual interview via Zoom.

The open day for the 2022 cohort will be held virtually on 21st May 2022. To register your interest in the 2022 cohort open day please email Jane Rhodes at degree@smaeinstitute.co.uk

The use of homeopathy in the treatment of hallux abducto valgus and bunion deformities.

A systematised review of the application of pseudo-crem

Ian Reilly
BSc, MSc, MRCPod, FRCPodS, FFPM RCPS(Glasg)

Consultant Podiatric Surgeon, Department of Podiatric Surgery, Northamptonshire Healthcare Foundation NHS Trust

Doctoral Student, Staffordshire University

ABSTRACT

Background: The most common pathological condition of the first ray is hallux abducto valgus. Treatment is initially provided by conservative means, with surgery indicated if non-surgical methods fail or are insufficient to control the patient's symptoms. Homeopathy is a treatment method based on the use of highly diluted substances which practitioners claim can cause the body to heal itself. Its use has been reported for treatment of hallux abducto valgus associated bursitis.

Methods: The aim of this review is to identify and critique the available evidence for the question: what are the outcomes of the use of homoeopathy in the treatment of hallux abducto valgus and/or bunion deformities? To achieve the objective, the author adopted a strategy that involved searching for evidence via electronic databases (NHS Healthcare Advanced Database Search engines AMED, CINAHL, EMBASE, and Medline), reference lists and Google scholar, and critically assessing the identified papers found.

Results: Eight records were found by the database search. After removal of duplicates this left three references, of which one was unobtainable. Further searches were made from reference lists and from free text searches of Google Scholar, but the only three of the further ten works identified could be retrieved. One of the three was discounted which left a total of four references for review. After critical appraisal the author found that the available literature is of low quality and that conflation with phytotherapy was common.

Conclusion: This review does not find support for the use of homeopathic treatments for hallux abducto valgus or bunion deformities as part of evidenced based healthcare practice. Further research into the application and effectiveness of homeopathy is required, which will need to include a distinction of whether true homeopathic or phytotherapy remedies are being studied.

INTRODUCTION

The first metatarsophalangeal joint and its deformities

The first metatarsophalangeal joint (1st MTP jt) is a condyloid synovial juncture that consists of the head of the first metatarsal, the base of the proximal phalanx, two sesamoid bones, six muscles and several ligaments[1,2]. The two most common pathologies affecting the 1st MTP jt are hallux limitus/rigidus (osteoarthritis) and hallux abducto valgus (HAV)[3] with the bunion being the more common of the two[4]. Numerous factors have been implicated in the aetiology of the condition, while grading the severity of the condition (mild, moderate, severe) commonly involves obtaining measurements from radiographs[5]. The bunion itself is a prominent metatarsal head with an overlying bursa that may become inflamed, secondary to the structural HAV deformity[6]. Treatment of a bunion is typically provided through conventional means. This includes conservative approaches initially such as shoe gear modification, padding, insole therapy, or corrective surgery. Though non-operative treatment may alleviate symptoms, this does not correct the deformity with surgery indicated if the pain of the deformity persists[7].

Homeopathy

The NHS defines homeopathy as a treatment based on the use of highly diluted substances which practitioners claim can cause the body to heal itself[8]. The Science and Technology Committee[9] state that:

Homeopathy is a 200-year-old system of medicine that seeks to treat patients with highly diluted substances that are administered orally. Homeopathy is based on two principles: "like-cures-like" whereby a substance that causes a symptom is used in diluted form to treat the same symptom in illness and "ultra-dilution" whereby the more dilute a substance the more potent it is (this is aided by a specific method of shaking the solutions, termed "succussion"). It is claimed that homeopathy works by stimulating the body's self-healing mechanisms.

Bell and Schwartz[10] acknowledge the scepticism and uncertainty about the mode of action of homeopathic remedies where like-cures-like (similia similibus curentu) and its lack of acceptance (or lack) by conventional medicine. They provide an evidence-based model for the potential nature and mode of action of homeopathic remedies via the Nanoparticle-Cross-Adaptation-Sensitization model.

Homeopathy and Podiatry

Despite the position of homeopathy on the fringes of medicine and healthcare, the Royal College of Podiatry (RCoP) provides information on podiatric homeopathy, accredits the foundation course for homeopathy for podiatrists, and has a Complementary Medicines Specialist Interest Group (SIG)[11,12]. Podiatric homeopathy features prominently in the services promoted at The Royal London Homeopathic Hospital[13] and membership of the Faculty of Homeopathy is available for those podiatrists that have completed a Licentiate in Homeopathic Podiatry: LFHom(Pod)[14].

Few studies appear in the podiatric or medical literature about homeopathy in relation to the treatment of foot conditions. The grey podiatric literature includes brief narratives on individual practitioners' experience and training. Such peer-reviewed literature which is available includes its use for the treatment of skin disorders[15], plantar fasciitis and HAV/bunions, the latter being the focus of this review.

A debate ensued in between Longhurst, Khan and Chadwick in Podiatry Now[16] following the earlier promotion of homeopathy[17].

Longhurst notes the robust evidence that shows homeopathy does not work and that the RCoP requires its members to display evidenced practice with a focus on outcomes; Chadwick states that homeopathy is a complementary therapy and that it can sit alongside but should not replace traditional podiatric practice; Khan defends the assertion that homeopathy is not evidenced based. This discussion served as the inspiration for this review which, as part of a series in the field, will look at the homeopathic treatment of HAV/bunions first.

DESPITE THE POSITION OF HOMEOPATHY ON THE FRINGES OF MEDICINE AND HEALTHCARE, THE ROYAL COLLEGE OF PODIATRY (RCoP) PROVIDES INFORMATION ON PODIATRIC HOMEOPATHY

METHOD

An initial scope of the literature suggested that a systematic review following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines would not be possible because too few articles were found, all of which appeared to be of low quality on first read through. Grant and Booth[18] identified 14 different types of literature reviews, one of which is a systematised review, which – as with the origin of this paper – is typically conducted as a postgraduate student assignment. The aim of this review is to identify and critique the available evidence for the question: what are the outcomes of the use of homoeopathy in the treatment of HAV and bunion deformities? To achieve the objective, the author performed a systematised review that involved searching for research evidence via the following sources:

1. Electronic databases
2. Reference lists
3. Google Scholar

The use of homeopathy in the treatment of hallux abducto valgus and bunion deformities.

Search strategy

- **Step 1:** The following databases were searched via the NHS Healthcare Advanced Database Search (HDAS) search engines: AMED, CINAHL, EMBASE, and Medline (see below),
- **Step 2:** Google Scholar was searched using key words identified from an analysis of the text words contained in the title and abstract of retrieved papers, and these key words used to search for articles (see below),
- **Step 3:** examining the reference lists of all identified sources from step 1 and 2.

The following MeSh terms and free text the keywords were used:

- *homeopath** - to capture derivates such as homeopathy and homeopathic
- *Tagetes* to capture use of marigold products
- *hallux** (truncated to collect hallux valgus or HAV)
- *bunion*

"((homeopath*).ti,ab OR (tagetes).ti,ab) AND ((hallux*).ti,ab OR (bunion).ti,ab)"

After an initial review, the use of the 'Patient-Intervention-Comparison-Outcome' (PICO) model for defining a clinical question was considered but as this was not a systematic review, it was deemed more appropriate to use 'Population–Concept–Context' (PCC) model.

The Joanna Briggs Institute recommends the PCC framework to identify the main concepts in review questions[19]:

- ***Population:*** all studies where the intervention is homeopathy for the treatment of HAV and/or bunions,
- ***Concept:*** articles with specific focus and/or statements on homeopathic remedies,
- ***Context:*** the review will include all study designs and book chapters; no date and language restrictions.

Inclusion criteria

- Articles where homeopathy was used for the treatment of HAV and/or bunions (all methodologies)

Exclusion criteria

- Interventions for the treatment of HAV and/or bunions other than homeopathy
- Post-operative homeopathic interventions
- Unobtainable articles

RESULTS

Following the execution of the search strategy, the identified records (titles and abstracts) were collated in HDAS (search no 857528). Eight records were identified. Removal of five duplicates left three references, only two of which were obtainable. Further searches were made

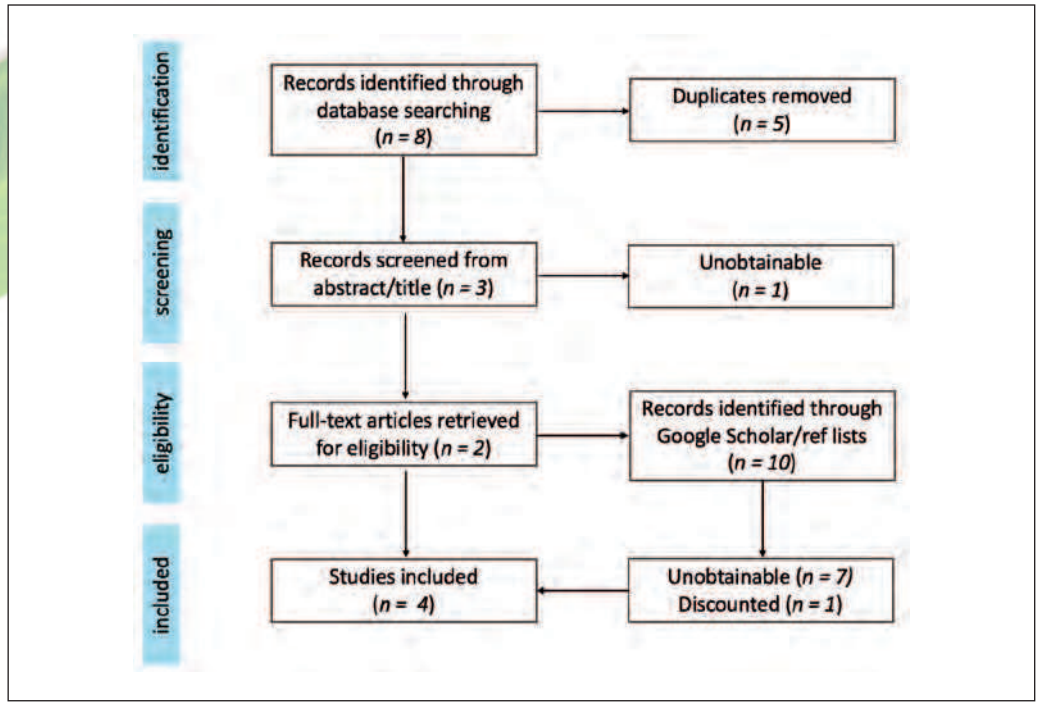


Figure 1: search strategy flowchart

from reference lists and from free text searches of Google Scholar. The author was only able to obtain three[20–22] of the further ten works thus identified. As these references were from the same author(s) and pertaining to the same body of work, it was decided that further attempts at retrieval of these was not necessary. A PhD thesis[21] was discounted as it in part formed by other references. This left a total of four references to critique (see Fig. 1).

Well-conducted systematic reviews are important for informing clinical practice and health policy[23], however, the data breadth and quality of the evidence produced was low and allowed only a narrative review; no synthesis was possible.

Reference 1

Khan[20] lists the following (see table 1) for treatment of bunions:

When there is a bunion from pressure (Sil.). If it is rheumatic enlargement of bursa (Rhod.). When inflamed (Vert. V.). Due to gout (Ben. Ac.). Or traumatic (Ruta). As a result of osteoarthritis (Led.)		
Dosage:	3x, 6x, 30 potency, one tablet two to four times a day	
Local Application:	Foot Bath: lotion of Kali.i. or required remedy twice a day Dressing: ointment or oil of required remedy in association with HV paddings or appliances 4-7 times a week	
Abbreviations:	Sil - silica	Ruta - ruta graveolens
	Rhod - rhododendron	Led - ledum
	Vert v - veratum viride	Kali i - kali iodatum
	Ben ac - benzoicum acid	HV - hallux valgus

Table 1: treatment of a bunion

This publication is unreferenced, and the tabulation of the data does not follow the accepted scientific protocol in its presentation. It has as a historical document but cannot be critiqued in a structured way. However, similar contemporaneous publications by the same author were referenced as recently as 2000[15].

Reference 2

Khan[24] describes the effect of Tagetes patula on hallux abducto valgus and the associated condition, bunion. The use of Calendula officialis is mentioned in the introduction as being widely used in homoeopathic medicine for the healing of ulcers. From the description of the use of marigold the reader is left to surmise that this is an example of phytotherapy rather than a homeopathic preparation of marigold (based on the homeopathic principles of ultra-dilution). Homeopathic treatment with marigold is discussed elsewhere[13,25] and this reference is therefore included here as this treatment modality is central to the homeopathy/phytotherapy overlap. The critique of this reference will follow the format of Derish and Annersley[26].

Study description: T. patula preparations had been used by the same author since 1993. Seeds of the same were cultivated and used to create a paste, tincture and oil. The paste was a composition of equal amounts of petals and leaves mixed with isopropyl alcohol; the tincture was prepared from equal amounts of stems, roots and flowerheads mixed with 80% isopropyl alcohol; the oil from an equal amount of roots and flower heads mixed with 80% arachis oil. Placebo paste was made from exhausted plant material, placebo tincture was 70% isopropyl alcohol and placebo oil was arachis oil.

60 patients were enrolled on the trial: 20 with bilateral HAV (Group A where one foot received the active preparation, and the contra-lateral foot received the placebo treatment) and 40 with unilateral deformity (split into Groups Ba and Bb for active and placebo treatment, respectively). X-rays were taken before and after treatment (for Group A only). The initial treatment was with a tincture applied to the bunion and application of cavity pad filled with paste (applied and secured to the foot). This was repeated weekly for four weeks with either the active or placebo compounds. After that point the patient self-applied tincture and oil compounds with tubefoam padding for a further four weeks.

A Vernier calliper was used to measure the width of the HAV joint. X-rays were taken before and after treatment (for Group A only). Photographs were taken, pain was measured on a 0-10 visual analogue scale (VAS) and subjective responses recorded on a four-point questionnaire for the effects and quality of treatment, and reduction of the bunion. Results were analysed using paired and unpaired t-tests (all groups) with a related t-test used for the angular measurements taken from radiographs (Group A only).

WELL-CONDUCTED SYSTEMATIC REVIEWS ARE IMPORTANT FOR INFORMING CLINICAL PRACTICE AND HEALTH POLICY

The use of homeopathy in the treatment of hallux abducto valgus and bunion deformities.

HOMEOPATHIC PRODUCTS SHOULD NOT BE CONFUSED WITH HERBAL REMEDIES. SOME HOMEOPATHIC PRODUCTS ARE DERIVED FROM HERBAL ACTIVE INGREDIENTS, BUT THE IMPORTANT DISTINCTION IS THAT HOMEOPATHIC PRODUCTS ARE EXTREMELY DILUTED AND ADMINISTERED ACCORDING TO SPECIFIC PRINCIPLES.

Key results

1. Photographic observation of the bilateral and unilateral HAV showed reduction in swelling and correction of deformity in the active groups but no obvious change noticed in the placebo groups,
2. Of the three study groups (Groups A, Ba and Bb) only data for group Ba is presented in the article. There is some confusion over the content of the subjective questioning regarding the effect of treatment in that the same question appears to have been asked twice, but to questions one and two there was a combination of 100% improvement (70% much better/30% better in Q1) in the two active groups; and static position or regression in the placebo groups,
3. The active treatment foot of Group A patients had pain relief, reduction in soft tissue and partial correction of angular deformity with minimal improvement in any domain for the placebo side,
4. Every patient in Group Ba had 10/10 pain at the beginning of the study and 0/10 pain at week 8.
5. The X-rays (from Group A only) were compared to determine a P value at <0.001 to determine improvement for both the hallux angle and intermetatarsal angle before and after treatment.

Limitations

1. Inclusion criteria were not included; exclusion criteria are mentioned in the abstract but not under the methodology,
2. Previous treatment (and effect) is not mentioned,
3. It is stated that 60 patients were required for the trial. This implies a power calculation had been performed prior to recruitment but this is not mentioned in the procedural narrative,
4. The study is double blinded placebo control trial but the method of blinding to the active ingredients is not clarified; nor is the method of randomisation,
5. It is not clear from the study what the definition of 'exhausted' entails regarding the placebo treatment,
6. It is not clear what the clinical background and knowledge base of the independence assessor was,
7. It is not clear how the Vernier calliper was used to measure the width of the HAV joint: whether this represents the width of the articulation, the medial evidence or the total width of the foot is not apparent,
8. No radiographs are presented in the published study,
9. Long term results are not available,
10. The research was sponsored by the Medical Trust - no information was provided on if the funding body was involved in the analysis of the results,
11. Only three references are included for this study and all three references quote the author: one from a conference presentation and two from undergraduate and postgraduate unpublished theses. This is an insufficient reference list.

Suitability of the methods used to test the initial hypothesis: The study design using bilateral and unilateral subjects with active and placebo groups is satisfactory but for the errors in the execution of the design (see above). There is insufficient detail for replication of this study. Given that there are significant methodological errors it is very difficult to have confidence in the conclusions drawn.

Quality of the results obtained: For Group Ba data (as presented in table form) it is remarkable to note that every patient initially complained of pain at 10/10 on a VAS. In a random HAV sample the expectation is that one would expect to see patients with varying degrees of reported pain. More remarkable is the 100% improvement (better/very much better) in subjective responses seen in the treatment samples compared to 100% 'no improvement' in the placebo groups.

There are different methods of obtaining angles and it is common practice to use weight bearing dorso-plantar views, taken unilaterally and in the angle of base of gait, to allow for repeatability of charting. In this study, it is not clear which angular measurements were examined, nor was it explained how the radiographic measurements were taken. The potential for intra-rater error is not considered, therefore the quality of radiological data reporting must be regarded as poor. No mechanism for the improvement in bony deformity or position is put forward.

Interpretation of the results: The interpretation of the results of the statistical tests (but given the points above) is acceptable.

Impact of the conclusions in the field. In the 25 years since the publication of this study it might be considered that the uptake of marigold for HAV has been limited. It is entirely plausible to hypothesise that a local effect from a therapeutic formulation of T. patula paste has an effect on local swelling and inflammation, but the mechanism for improvement in angular deformity is much more difficult to explain

and topical remedies have not (yet) replaced conventional methods for bunion correction. The study concluded at the eight-week point and we do not know what the long-term effects are/were.

Reference 3

In this reference, marigold therapy preparations consisting of tincture, oil and paste are used with protective pad for HAV/bunion[22]. A case study notes:

> *"A female patient aged 79 suffered with bilateral HAV and ACB with medial deviation of the big toe and painful, swollen soft tissue at the 1st MTPJ. She was treated with Marigold Therapy preparations once weekly for 4 weeks and then prescribed follow-up home treatment using the tincture and oil. Arnica montana 30 and Ruta graveolens 30 once a day alternately for 2 weeks were prescribed. The patient reported that the pain was relieved within 24 hours of the first treatment. The swelling over the joint was resolved within 4 weeks".*

This is the same treatment strategy as per reference two, but with the addition of ***A. montana*** and ***R. graveolens***. On page 97 of this reference, further treatment is listed for bursitis using ***Apis mel***, and HAV using ***Rhus tox*** (see table 2). This would appear to be more a traditional homoeopathic approach but there is insufficient detail to enable a useful critique of this paper.

Bones and joints	Homeopathic medicine
Bursitis	Apis mel
Hallux abducto valgus	Rhus tox

Table 2: adapted from [22]

Reference 4

A case study of the same process as reference two was presented some years later[27]. Two letters to the Editor of Podiatry Now followed its publication and the reader is directed to these for the detail of the critique[28,29]. In this paper it is still not clear if the marigold tincture, paste and oil were of homeopathic or pharmacological preparations. However, this paper specifies that homoeopathic remedies were used post-procedure, namely ***Arnica montana*** four globules three times a day for three days, followed by ***Ruta graveolens*** four globules twice a day for a further five days. The paper should therefore have been more accurately titled ***'Treatment of a bunion with homeopathic podiatry AND marigold paste'*** which then brings into question if either or both formulations are needed to see the effects claimed later in the article.

The article describes a reduction in swollen soft tissue density of 38.9% and 40% (right and left foot, respectively). The photographs presented are of low resolution but do not show a marked improvement from the pre- to post-treatment position. Hallux abductus position improved slightly post-procedure but the inter metatarsal angle (IMA) improved more dramatically, especially in the right foot where the IMA reduced from 17 to 12 degrees, a 29.4% reduction. Hardie [28] expands in his letter:

> *The claim that the radiographic angles changed pre and post treatment is central to the article. The angles shown on the X-rays did not appear to match those in the tables. I therefore measured them myself and found them to be different, some quite markedly. I can accept a degree or two difference that could be put down to inter observer variance but the hallux abductus angles were up to 14 degrees out.*

The temporary effect of taping on hallux position during X-ray examination seems to have been overlooked and, again, the statement that a topical medicament can - and by what means - affect position change is not substantiated. The references regarding bunion surgery outcomes are limited and historical. Following the receipt and publication of the letters, the Editorial Committee acknowledged that this paper received an inadequate review in response to the letters.

One study that was unobtainable has an abstract available via HDAS[30].

> *Abstract: This is a report of controlled double-blind trials on hallux valgus (bunions) patients using a marigold preparation (Tagetes erecta sp.). Preliminary trials on 100 patients using this remedy had proved beneficial. 100 female patients, between the ages of 20 and 80, were selected for the controlled trials. In each case hallux valgus had been diagnosed and one foot was treated with the Marigoldin (sic) Mass, and the other left with no treatment. After four weekly treatments each patient was given a pack of the remedy to continue the applications at home, having agreed to take part in the double- blind trials. Both feet of the patients were measured, photographed and x-rayed before treatment began and this was repeated at certain stages durig (sic) the treatment period which lasted 43 weeks. Significant levels of difference (sic) between results in treated and untreated feet were calculated. Nearly all the patients (82%) stated they felt much better as a result of the treatment, and 18% admitted to some improvement. Improvements were recorded of other foot conditions such as hard skin and swelling of the soft tissues. Many patients said that as a result of the success of the treatment the quality of their lives had been greatly improved. A formula patented by the Marigold Treatment Centre Homoeopathy and Chiropody Laboratories Ltd.*

THE PAPERS REVIEWED APPEAR TO CONFUSE AND CONFLATE THE USE OF MARIGOLD PRODUCTS WITH WHAT WOULD BE CONSIDERED TO BE TRUE HOMOEOPATHY

DISCUSSION

Shang et al[31] note that the preparation of remedies involves serial dilution, commonly to the extent that no molecules of the original substance remain, with vigorous shaking between dilutions (here referred to as "potentisation") and opine that claims of efficacy seem implausible in the light of current knowledge. They acknowledge that though bias is present in both homeopathic and conventional placebo-control trials, they state that there is weak evidence for the specific effect of homoeopathic treatments but strong evidence for specific effects of conventional interventions. They concluded that this finding was compatible with the notion that the clinical effects of homoeopathy are placebo effects and could be explained by a combination of methodological deficiencies and biased reporting. Bell and Schwartz[10] state that homeopathy is one of the most popular forms of integrated medicine, but this statement is a logical fallacy, specifically the one known as the Bandwagon Fallacy, or an appeal to popularity: to note that many people do something as an attempted form of validation. That said, a simple Google search of 'homoeopathy for bunions' achieves just under 2 million hits with statements such as the following being made: ***"Homeopathic treatment for Bunion*** (sic) can provide complete cure for Bunions. With the help of natural Homeopathic remedies, the pain and swelling around the big toe is reduced, followed by complete cure of the bunion"[32]. It is not difficult to understand why a homoeopathic remedy would appeal to many over the potential risk and complication of invasive surgery.

The papers reviewed appear to confuse and conflate the use of marigold products with what would be considered to be true homoeopathy. In the studies reviewed, it was difficult to be sure if remedies offered are truly homeopathic or are in fact herbal, and therefore not at an ultra-diluted dose. For example, in the appendix on page 246 (Improving the success of homoeopathy. Clinical application of homeopathic podiatry us used at the Royal London Homeopathic Hospital, 15-14/04/1999) of a PhD thesis[21], Khan states that homoeopathic podiatry is "a method of treatment for conditions of the skin, bones and nails which were developed by combining homoeopathy with podiatric practice". A webpage on Homeopathic Podiatry[33] states: ***"Homeopathic podiatry is a term used for a podiatrist who uses oral homeopathic medicines, topical phytotherapy (Marigold Therapy) in podiatric management"***. This might explain the confusion between what is reported as homoeopathic when the methodology describes a concept which appears to be more herbal in nature. The Science and Technology Committee report[9] state that:

> ***"homeopathic products should not be confused with herbal remedies. Some homeopathic products are derived from herbal active ingredients, but the important distinction is that homeopathic products are extremely diluted and administered according to specific principles."***

Phytotherapy is the use of plant-derived medications in the treatment and prevention of disease[34]. Arnica is a useful comparator here. Brito el al[35] state there are two possibilities for ***Arnica montana*** as a herbal remedy: oral use in diluted doses as a homeopathic drug or topical use in pharmacological dosages. Their systematic review on topical (non-homeopathic) ***Arnica*** for the treatment of pain, swelling and bruises concluded that its efficacy in doses of 10% and below is not supported by the available evidence. An old systematic review from 1998 found that the hypothesis claiming that homeopathic ***Arnica*** is clinically effective beyond a placebo effect was not based on methodologically sound placebo-controlled trials[36].

It is entirely plausible that a compound made with ***T. patula*** has biological or therapeutic activity. Indeed, mention is made of the various chemicals that have a role in the relief of inflammation and pain by Khan[24]. More recent work also supports the potential anti-inflammatory effects of marigold[37]. Interestingly, this recent paper by Chkhikvishvili ***et al*** cites Khan's work which supports the need for this up to date, structured critique of the literature. The role of a therapeutic preparation topical marigold in the longer-term management of superficial HAV bursitis is a separate research question and would make for a valuable review in its own merit.

In planning and evaluating HAV surgery, the three measurements that are considered the most important are the hallux valgus (HV) angle (also known as hallux abductus angle), the intermetatarsal I–II angle (IMA), and the tibial sesamoid position (TSP)[38]. 'Hallux angle' as used in reference 2 is incorrect terminology; one assumes this is meant to mean HV angle. There are different methods of obtaining and charting the angles taken and the potential for inter- and intra-rater error should have been considered[39]. The clinical and statistically significant improvement in angular position is an important finding but one cannot conclude that this is an accurate finding from the studies available. The pain from bunions comes from a combination of medial eminence irritation and subluxation of the joint which can be at both the metatarso-phalangeal and metatarso-sesamoid articulations. It would be very helpful to understand any mechanism by which the application of a topical medicament (homeopathic or otherwise)

addresses the symptoms from both superficial soft tissue irritation and correction of bony deformity. It would also be useful to know whether homoeopathy is useful for different stages of bunion deformity or if any effect on delaying regression is observable. What effect homoeopathy (or topical phytotherapy) could have on biomechanical and/or anatomical dysfunction of HAV is unclear.

Just beyond the scope of this review is the compound but included for completion, Traumeel S®, an over the counter (OTC) homeopathic preparation composed of highly diluted extracts from a combination of plants (for example, ***Arnica***) and two minerals. Singer et al[40] performed a randomized, double blind, placebo-controlled trial to evaluate its efficacy in minimizing post-operative pain and analgesic use following surgical HAV correction. It was not found to be superior to placebo in minimizing pain or analgesic consumption over the two weeks of the trial, however a transient reduction in the daily maximum post-operative pain score was observed on the day of surgery. Its use has also been reported for primary joint pain[41].

The Science and Technology Committee[9] conclude that the systematic reviews and meta-analyses conclusively demonstrate that homeopathic products perform no better than placebos. Looking internationally, the National Health and Medical Research Council (NHMRC), Australia's highest medical research body, conducted an extensive assessment of scientific evidence to develop a position statement on the use of homeopathy, evaluating more than 1800 papers, systematic reviews, published guidelines, and information provided by homeopathy advocacy groups. They conclude that "there are no health conditions for which there is reliable evidence that homeopathy is effective"[42].

When papers or studies are published which reference randomised controlled trials to support the statement that homeopathy for foot conditions is evidenced-based, trials of poor methodological quality should not be used as a validation of this scientific claim. As papers reviewed here continue to be used and quoted to support the pro-homeopathy argument[43], it is therefore scientifically valid to publish a critique of such work. Based on a critique of the currently available evidence and data, this review finds that the use of homeopathy in the treatment of HAV/bunion deformities is not supported in evidence-based practice. This is lamentable given the obvious dedication of some practitioners who have attempted to systematically quantify podiatric homeopathy's merits.

Critiquing this review, a specific search of homeopathic databases was not performed, which might have yielded further sources. The unobtainable published references mentioned above are all by the same author and appear to be (from the numbers of pages listed in the references) short articles. It is unclear if they would have developed the scientific argument further than those references reviewed, however without access to the unpublished theses we do not know if relevant data has been overlooked. This limitation of authorship across the topic makes it difficult to control bias, as is typically the case for non-systematic reviews. This study was performed by one researcher, which may bring in researcher bias, compounded by professional bias as a podiatric surgeon.

CONCLUSION

Based on a critique of the literature, this review concludes that the current evidence base is of low quality and does not support the use of homeopathic treatments for HAV/bunions. The literature supporting the use of homeopathy is subject to confirmation and publication bias and, given that the studies presented are 19 and 25 years old, it is disappointing that further literature from other researchers in the intervening years to support or substantiate these findings is lacking. Unless, or until, more robust studies are produced to support the use of homoeopathy in these circumstances one must conclude that only conventional methods for treating HAV should be offered as part of evidenced based healthcare practice. Further research into the application of homeopathy is therefore required to elevate it beyond a topical 'pseudo-crem'. Future studies should be disseminated in peer reviewed, high-impact journals, to include a distinction of whether true homeopathy or herbal/phytotherapy remedies are being utilised or studied.

Notes:

REFERENCES

1. Alvarez R, Haddad RJ, Gould N, Trevino S, Alvarez RG. The simple bunion: anatomy at the metatarsophalangeal joint of the great toe. 1984.
2. McSweeney S. First metatarsophalangeal joint osteoarthritis. A clinical review. Journal of Novel Physiotherapies 2016;06:1–4. https://doi.org/10.4172/2165-7025.1000293.
3. Mann RA. Disorders of the first metatarsophalangeal joint. Journal of the American Academy of Orthopaedic Surgeons 1995;3:34–43.
4. Raikin SM. Uncommon disorders of the first ray. Techniques in Foot & Ankle Surgery 2013;12:2.
5. Menz HB, Munteanu SE. Radiographic validation of the Manchester scale for the classification of hallux valgus deformity. Rheumatology 2005;44:1061–6. https://doi.org/10.1093/rheumatology/keh687.
6. Ferrari J. Bunions. Clinical Evidence 2009;03.
7. Wülker N, Mittag F. The treatment of hallux valgus. Deutsches Aerzteblatt Online 2012:857–68. https://doi.org/10.3238/arztebl.2012.0857.
8. NHS. Homeopathy 2018. https://www.nhs.uk/conditions/homeopathy/ (accessed May 22, 2020).
9. Science and Technology Committee. Fourth Report. Evidence Check 2: Homeopathy 2010. https://publications.parliament.uk/pa/cm200910/cmselect/cmsctech/45/4502.htm (accessed May 20, 2020).
10. Bell IR, Schwartz GE. Adaptive network nanomedicine: an evidence-based integrative model for homeopathic medicine effects on complex living systems. vol. 5. 2013. https://doi.org/10.2741/s400.
11. Khan MT. Homeopathic podiatry special interest group. Podiatry Now 2009;12:53.
12. The Society of Chiropodists and Podiatrists. Homeopathic Podiatry. Homeopathic Podiatry 2009. https://foothealthpodiatry.co.uk/wp-content/uploads/2013/07/Homeopathic-Podiatry-3-.pdf (accessed May 26, 2020).
13. Khan MT, Khan MT. Clinical application of homeopathic podiatry as used at the Royal London Homeopathic Hospital (RLHH). Br Homeopath J 2000;89:S53.
14. Faculty of Homeopathy. Primary Health Care Examination (PHCE) Podiatry Guidelines 2019-20. Podiatry Guidelines 2019-20 2020. https://facultyofhomeopathy.org/wp-content/uploads/2019/09/PHCE-Podiatry-guidelines-2019-20.pdf (accessed May 22, 2020).
15. Khan MT, Khan MT. Treatment of plantar hyperkeratosis with homeopathic podiatry. Podiatry Now 2000;3:502–5.
16. Longhurst B, Chadwick P, Khan MT. Should homeopathy have a place in podiatric practice? Podiatry Now 2017;2:45.
17. Peatfield L. Homeopathy: a natural way to enrich your general podiatry practice. Podiatry Now 2017;2:36.
18. Grant MJ, Booth A. A typology of reviews: An analysis of 14 review types and associated methodologies. Health Information and Libraries Journal 2009;26:91–108. https://doi.org/10.1111/j.1471-1842.2009.00848.x.
19. The Joanna Briggs Institute. The Joanna Briggs Institute reviewers' manual 2015.
20. Khan MT. Homeopathic Therapeutics for Podologists. 2nd ed. Institute of Molecular Medicine; 1986.
21. Khan MT. PhD Thesis. Phytochemical and biological studies of Tagetes erecta and its clinical evaluation in the treatment of hallux abducto valgus and its associated condition, bunion. 1999.
22. Khan MT. How I treat some common foot problems. British Homoeopathic Journal 1997;86:92–7.
23. Lavis JN, Posada FB, Haines A, Osei E. Use of research to inform public policymaking. The Lancet 2004;364:1615–36.
24. Khan MT. The podiatric treatment of hallux abducto valgus and its associated condition, bunion, with Tagetes patula. Journal of Pharmacy and Pharmacology 1996;48:768–70. https://doi.org/10.1111/j.2042-7158.1996.tb03968.x.
25. Khan MT, Khan MT. Clinical evaluation of homeopathic podiatry in the treatment of diabetic foot ulcers. Br Homeopathic Journal 2000;89:S67.
26. Derish PA, Annesley TM. How to write a rave review. Clinical Chemistry 2011;57:388–91. https://doi.org/10.1373/clinchem.2010.160622.
27. Khan MT, Khan MT. Case report. Treatment of a bunion with homeopathic podiatry. Br Journal Podiatry 2002;5:43–6.
28. Hardie RJ. Re: Treatment of a bunion with homeopathic podiatry. Podiatry Now 2002;5:644.
29. Kilmartin, T E. Re: Treatment of a bunion with homeopathic podiatry. Podiatry Now 2002;5:644.
30. Khan MT. Report of the clinical trials for Tagetes erecta sp. (Marigold) in the treatment of hallux valgus (bunions). (Not Listed) 1986.
31. Shang A, Huwiler-Müntener K, Nartey L, Jüni P, Dörig S, Sterne JAC, et al. Are the clinical effects of homoeopathy placebo effects? Comparative study of placebo-controlled trials of homoeopathy and allopathy. The Lancet 2005;366:726–32.
32. Sharma V. Homeopathic Remedies For Bunion n.d. https://www.drhomeo.com/homeopathic-treatment/homeopathic-remedies-bunion/ (accessed January 5, 2021).
33. Khan MT. Podiatric homeopathy. (Undated) n.d. https://www.britishhomeopathic.org/charity/how-we-can-help/articles/conditions/p/top-5-reasons-we-visit-the-podiatrist/ (accessed May 24, 2020).
34. Falzon CC, Balabanova A. Phytotherapy: An introduction to herbal medicine. Primary Care - Clinics in Office Practice 2017;44:217–27. https://doi.org/10.1016/j.pop.2017.02.001.
35. Brito N, Knipschild P, Doreste-Alonso J. Systematic review on the efficacy of topical arnica montana for the treatment of pain, swelling and bruises. Journal of Musculoskeletal Pain 2014;22:216–23. https://doi.org/10.3109/10582452.2014.883012.
36. Ernst E, Pittler MH. Efficacy of homeopathic Arnica. A systematic review of placebo-controlled clinical trials. Arch Surg 1998;133:1187–90.
37. Chkhikvishvili I, Sanikidze T, Gogia N, Enukidze M, Machavariani M, Kipiani N, et al. Constituents of French Marigold (Tagetes patula L.) flowers protect Jurkat T-cells against oxidative stress. Oxidative Medicine and Cellular Longevity 2016;2016. https://doi.org/10.1155/2016/4216285.
38. Coughlin MJ. Hallux valgus: an instructional course lecture at the American Academy of Orthopaedic Surgeons. J Bone Joint Surg Am 1996;78:932–66.
39. Saro C, Johnson DN, Martinez De Aragón J, Lindgren U, Felländertsai L. Reliability of radiological and cosmetic measurements in hallux valgus. Acta Radiologica 2005;46:843–51. https://doi.org/10.1080/02841850500270852.
40. Singer SR, Amit-Kohn M, Weiss S. Traumeel S® for pain relief following hallux valgus surgery: a randomized controlled trial. BMC Clin Pharmacol 2010;10(1) 2010;10. https://doi.org/10.1186/1472-6904-10-9.
41. Hahn J. A closer look at homeopathic modalities for joint pain. Podiatry Today 2007;20:48–52.
42. National Health and Medical Research Council. NHMRC Information Paper: Evidence on the effectiveness of homeopathy for treating health conditions. Canberra: 2015.
43. Khan MT, Cummings M, Fisher P. Complimentary and Integrated Medicines. In: Burrow G, Rome K, Padhiar N, editors. Neale's Disorders of the Foot and Ankle. 9th ed., 9780702062230; 2019;76–89.

Supplying the professional

Members Exclusive Offer!

15% OFF

Limited Time Only While Stocks Last

SAVE £71.25

Twister Portable Drill

The upgraded Twister model features an attractive modern design, up-to-date microprocessor technology and a keyboard with soft keys. The softkeys allow the user to vary the speed with the 'plus' or 'minus' keys or programme speed settings that can be accessed via the three memory keys. There is also the option to reverse the direction of rotation or pause rotation using these keys. Practical storage for the handpiece is integrated into the device. The slim shaped gripping case makes fatigue-free and comfortable handling, in both the fist and in the writing position, possible. Mains operated.

Specifications:

Voltage: 230 Volt / 50/60 Hz
Power input: 30 Watt
Speed: Max. 30,000 rpm
Controller dimensions: L: 160mm x H: 100mm x D: 205mm
Weight: 1.4kg
Handpiece dimensions: L: 125mm
Handpiece weight: 105gms

E6073 ~~**RRP £474.99**~~ **Offer Price £403.74**

Order online at **www.podiacare.co.uk** and enter code '**TWISTER22**' at checkout or call us on the number below

Telephone
01628 632 449

Answerphone
01628 637 625

Email
orders@podiacare.co.uk

PODIACARE HEALTHCARE
Manufacturers of Footcare Products, Instruments and Medical Equipment

Prices exclude VAT. Offer expires 31/05/2022.

Aging – Theories and Fall-Out

Part III – Body Changes Associated with Getting Older

By Tracey O'Keeffe
MA (Education), BSc (Critical Care), RN, MAFHP, MCFHP

Programme Lead
(Diploma in Foot Health)

THE MAJOR THEORIES SURROUNDING CHANGES TO THE INTEGUMENTARY SYSTEM REVOLVE AROUND OXIDATIVE STRESS, FREE RADICAL, GENETIC AND AUTOIMMUNE

INTRODUCTION

This is the third paper is this series. The first instalment explored why and how we may age, looking generally at some of the theories behind the aging process. We then progressed to look at specific body changes that occur from a systems approach. This second paper examined the respiratory and circulatory system, the gastrointestinal and excretory system and finally the reproductive system. The focus now moves to the final four remaining body systems in Figure 1: the integumentary and sensory systems, the musculoskeletal system, the immunological system and the neuroendocrine system.

INTEGUMENTARY AND SENSORY

The Integumentary System

The integumentary system comprises the skin and its associated elements, including the hair, nails, sweat glands and sensory receptors (Tortora and Derrickson 2011). It has many functions. As the skin covers the body it provides protection and it also assists with thermoregulation through sweat evaporation and changes to peripheral blood flow. The presence of receptors allows the skin to recognise various cutaneous sensation include light touch, pain, vibration and pressure. The skin is also vital in the synthesis of vitamin D.

The major theories surrounding changes to the integumentary system revolve around oxidative stress, free radical, genetic and autoimmune (Cefalu 2011). As the body gets older, there are cellular changes. Langerhans cells, microphages and mast cells all reduce in number (Tortora and Derrickson 2011, Cefalu 2011). This weakens the ability of the body to initiate and maintain an immune result, thereby increasing the likelihood of infection. The risk of a negative outcome of infection is compounded by the other changes occurring in the skin.

The layers within the skin alter both in structure and in volume. There is a loss of adipose tissue creating an apparent reduction in subcutaneous fat layer and reduced "padding". Decreased numbers of fibroblasts result in less collagen and elastic fibres. Henderson (2006) suggests this senescence is connected to poor wound healing with implications for the management of chronic wounds. The collagen fibres in the dermis also become more stiff, more disorganised and start to break, with the elastic fibres losing their flexibility and forming into clumps (Tortora and Derrickson 2011). These changes manifest as the wrinkles that are visibly evident in older, less resilient skin. However, apart from the cosmetic change, the altered collagen structure, alongside long-term exposure to UV light through the sun, also means that there is an increased risk of skin cancer (basal cell, squamous cell and melanoma) (Lange and Grossman 2021, Cefalu 2011). Cefalu and Nesbit

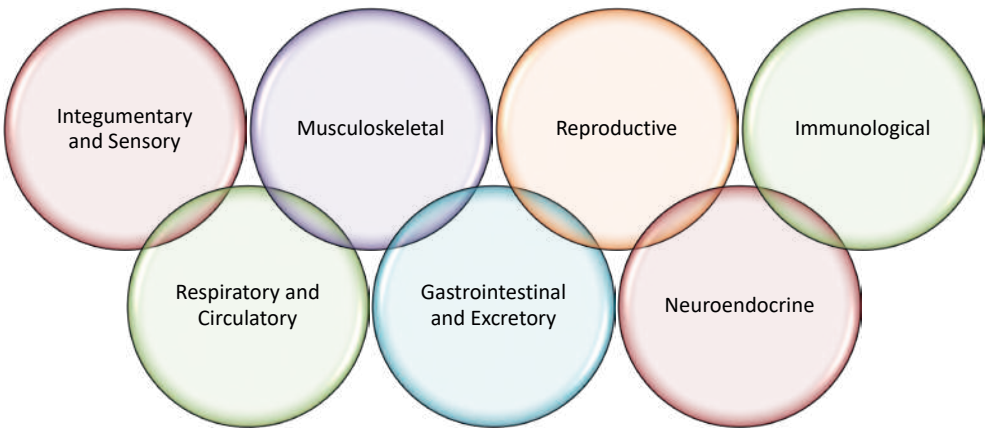


Figure 1 – discussing the body as different systems

(2006) also itemise other changes including alteration in pigmentation, increased likelihood for the skin to blister and reduction in dermal clearance of chemical agents. This highlights the risk of infection as well as inflammatory conditions such as dermatitis.

Figure 2 – older skin

Within the dermis there is also reduction in the size of the sebaceous glands. The already weakened skin now becomes dryer and more likely to break. Blood vessel walls thicken and become less permeable. Cell migration from the deeper basal layer to the surface epidermal layer slows (Tortora and Derrickson 2011). All of these elements further increase problems with healing should a wound or insult occur, such as skin tears and pressure ulcers. The ability of older skin to produce vitamin D is also affected and this has added potential to alter healing capacity (Razzaghi et al. 2017). Guo and DiPietro (2010) suggest that this may be due to regulation of epidermal keratinocytes. Significant lack of vitamin D can also result in osteomalacia in adults (Cefalu 2011). Problems with thermoregulation can also occur as sweat glands become less productive and lose ability to cool the body efficiently when needed.

As well as the skin, there can be changes to hair growth and colour. Cefalu (2011) explains that the stages of hair growth are affected. The telogen phase (where the hair follicle is resting) contains more hair but as the cycle moves to the anagen phase (new growth), the time shortens and therefore less hairs develop resulting in baldness. Changes to follicular melanocyte activity creates the familiar grey hair in older age (Tortora and Derrickson 2011, Cefalu 2011).

Figure 3 – changes to hair colour and growth

Nail growth changes with age too. Abdullah and Abbas (2011) suggest that increased thickness may occur alongside alterations in general morphology such as the nail contouring. They note that it is not fully understood why the nails are affected but that it may related to a poorer peripheral blood supply and increased UV exposure. There appear to be changes to the iron and calcium present in nail composition (Baran and Dawber 1994) which could impact on the quality of the nail itself. Tortora and Derrickson (2011) suggest that both hair and nail growth begins to diminish within the second and third decades of life with Singh et al. (2005) stating that between the ages of 20 and 100, nail growth reduces by approximately half a percent per year.

AS WELL AS THE SKIN, THERE CAN BE CHANGES TO HAIR GROWTH AND COLOUR

FROM BIRTH
THROUGH TO
ADOLESCENCE
THE BODY CREATES
MORE BONE THAN IT
LOSES BUT THE RATES
EQUALISE AS WE
REACH YOUNG
ADULTHOOD

The Sensory System also undergoes alterations with age. The senses include taste, smell, touch, hearing and vision. Cavazzana et al. (2018) suggest that impairment of the senses is not global and that each individual element may vary with each person. This is a controversial view with others believing that the decline is more generic and consistent across all the five senses (Pinto et al. 2017; Correia et al. 2016). It is clear, however, that the senses are affected with age (see Figure 4) and that this can impact the person in many different ways from problems both from a practical and psychosocial perspective.

MUSCULOSKELETAL

The musculoskeletal system provides the structure and framework of the human body and facilitates movement as well as providing protection to vital and potentially vulnerable internal organs. As we age, there is loss of both bone and muscle mass. Cefalu (2011) suggests that peak bone density is evident in our 30's. Tortora and Derrickson (2011) explain how this is related to changes in bone deposition and resorption. From birth through to adolescence the body creates more bone than it loses but the rates equalise as we reach young adulthood. With changes to sex hormones (as discussed in Part II) and the advancement of older age, the work of the osteoblasts in bone deposition does not match the speed of resorption by the osteoclasts. O'Flaherty (2000) suggests that the changes not only reflect age, but also hormone and vitamin levels. Once changes start, demineralisation of the bone can result in mass reduction of approximately 8% in women every ten years and 3% in men (Tortora and Derrickson 2011).

Tensile strength also alters due to slowing of collagen synthesis and the resultant impact on the extracellular matrix (Tortora and Derrickson 2011) with the bone architecture changing and generalised thinning of bone (Cefalu 2011). This creates bones that are more brittle and liable to fracture.

As well as the bones themselves, there are notable changes to the vertebrae. Cefalu (2011) discusses how the average person loses height as they age. This is related to a decrease in the height of vertebral body with thinning of the discs, more flexion in the knees and hips and flattening of the arches of the feet. There is trabecular bone disruption, reducing the strength of the bones of spine, again increasing risk of fracture. Alongside this the cortical thickness reduces (Mosekilde 1993) and this reduces the compressive strength in particular (Edwards et al. 2001). The changes to the spinal structures is often evident in the hunched posture and curvature seen in the older population.

There are also changes to the water content of musculoskeletal structures. These include the cartilage, the synovial fluid volume and the connective tissue, such as tendons and ligaments (Hamerman 1998; Hofer et al. 2005). The connective tissue sees alterations in the proteoglycans which work to provide hydration. Lack of hydration can result once again in an inability to withstand compressional forces (Yanagishita 1993). With cross-linking changes associated to old age (Hamerman 1998), the collagen becomes stiffer as the chemical-physical stability is altered (Cefalu 2011). The result can be seen as a reduction in range of motion of the

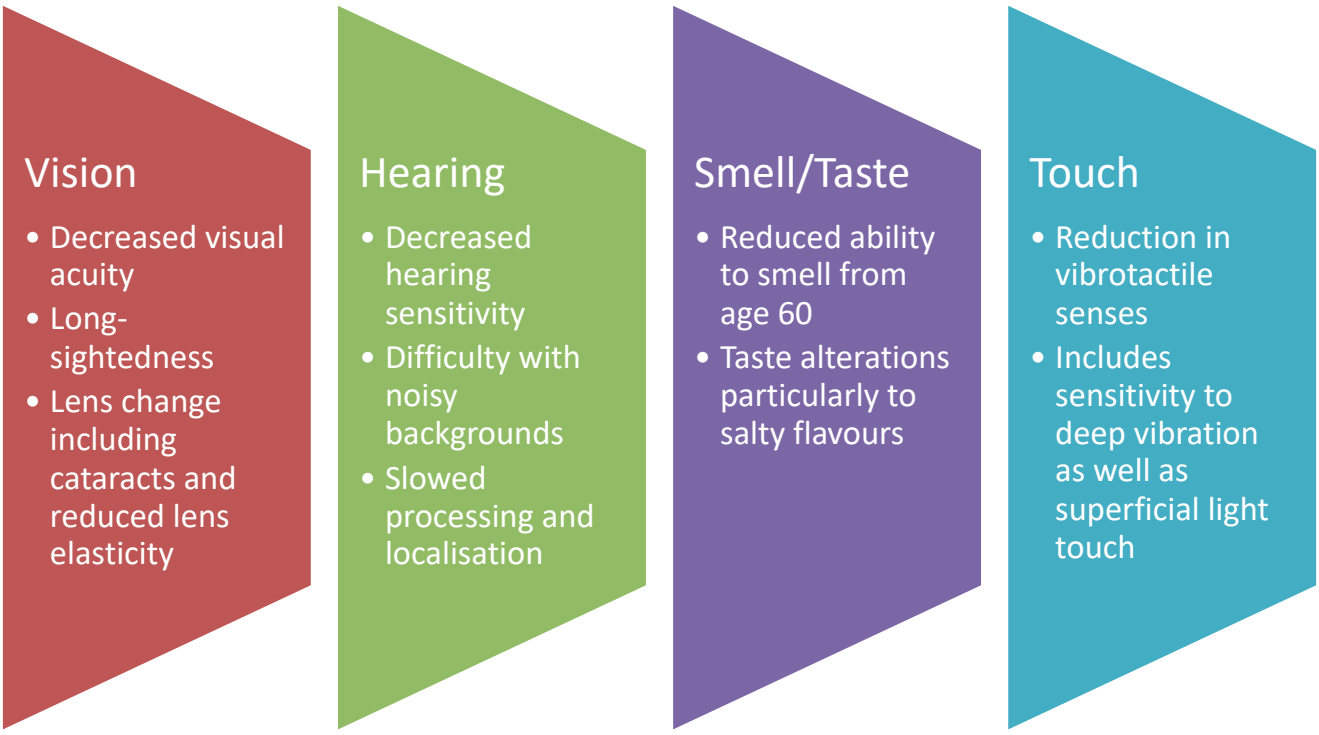


Figure 4 – changes to the sensory system.
Based on: Decorps et al. 2014; Gates and Mills 2005; Hummel et al. 2007; Iwamoto et al. 2013; Lin et al. 2005; Owsley 2011; Seubert et al. 2017)

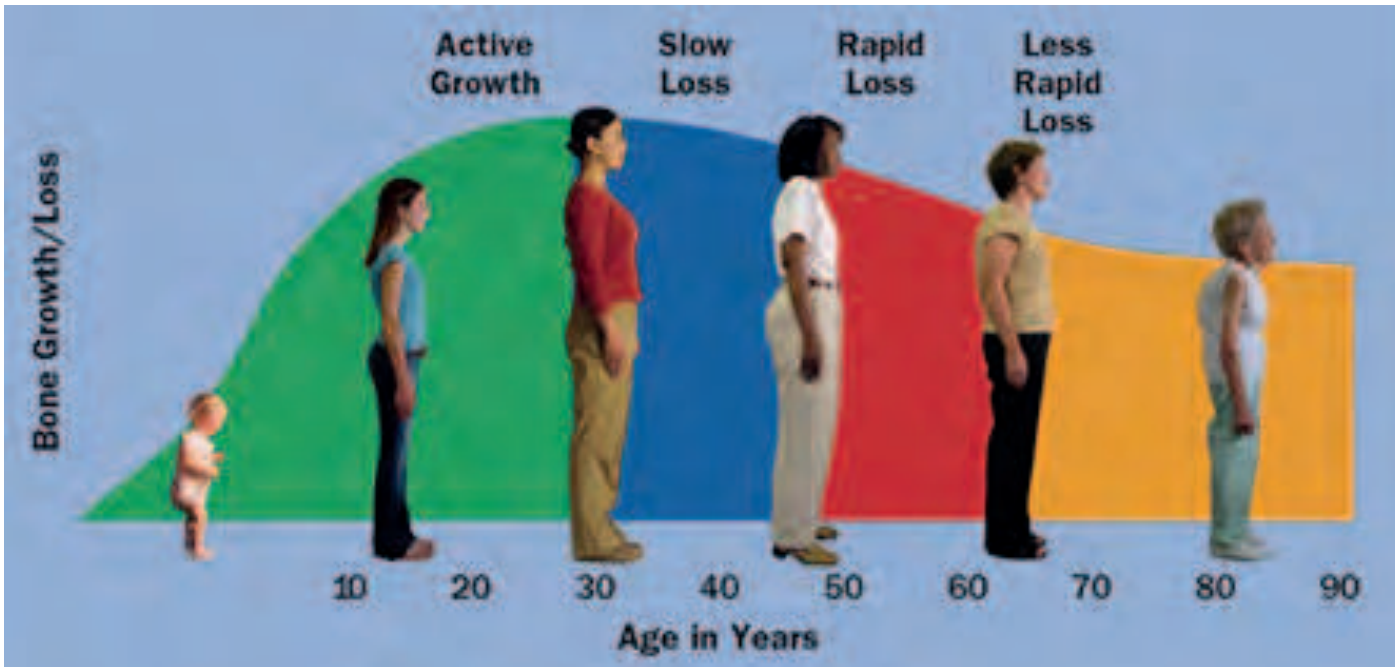


Figure 5 – changes to bone growth with age

lower extremity joints (Nigg et al. 1992; Nitz and Low-Choy 2004; Parker 1989) as well as other areas in the body.

The final area to consider in the musculoskeletal system is the muscles. Doherty (2003) suggests the size and number of muscle fibres reduces with age resulting in an overall decline in muscle mass. Tortora and Derrickson (2011) discuss how there is a slow progressive loss of skeletal muscle between the ages of 30 and 50 (10%) with a more dramatic increase between 50 and 80 years of age (40%). This reduction results in reduced strength and flexibility as well as a slowing of reflexes with the lower limbs being more commonly affected. As the lean body mass decreases, there is an increase in connective tissue, fat and adipose tissue. The changes to the muscle structure itself is often compounded by an alteration in the innervation particularly affecting the actual function of the type 2 (fast-acting) myofibrils (Jackson 2009).

IMMUNOLOGICAL

As we age, it is evident that the body becomes more susceptible to infection and malignancy. Alongside this, there is a reduced response to vaccines (Tortora and Derrickson 2011; Weyand and Goronzy 2016). Keilich et al. (2019) comment that the increased level of risk is compounded by the comorbidities associated with the longevity of modern life. Haynes (2020) discusses how there is little understanding about the mechanisms behind the changes to both innate and adaptive immunity in the older adult. However, it does appear that production in the bone marrow goes down, reducing the amount of T cells and B cells. The T cells are less sensitive to antigens and the B cells also seem to become less responsive, resulting in reduced levels of antigens (Tortora and Derrickson 2011). However, Montecino-Rodriguez et al. (2013) also suggest that one main problem is the diminished function of the lymphocytes. What is clear is that each individual has a different response and there is some degree of unpredictability from person to person. The variable level of illness associated with influenza is of particular note and highlights this point well (Thompson 2003) and furthermore, the impact of vaccine protection can vary significantly (McElhaney and Dutz 2008; Reichert et al. 2004; Fleming and Elliot 2005).

Although it is evident that the response to infection can be ineffective in the elderly, there is also much exploration into the concept of inflammaging (Freund et al. 2010; Childs et al. 2017; He and Sharpless 2017). Franceschi et al. (2000) highlight how this can have a high risk for mortality and morbidity having stemmed from a chronic, consistent drive in the immune system predominantly by macrophages. For some people, instead of a reduction in antibody production as outlined earlier, it can result in high levels (Tortora and Derrickson 2011) with an unusual release of cytokines triggered by a perceived chronic inflammation (Henry et al. 2011). Essentially, there are changes to the cells (CD4, CD8, T and B Cells), adjusting the adaptive immunity and creating an inflammatory response which is increased in both duration and intensity (Cossarizza et al. 1996; Linton and Dorschkind 2004; Weyand and Goronzy 2016). This can end up with tissue damage and inflammatory disease. Indeed, it may be that this chain of events, inflammaging, could be a causative factor in many of the age-related conditions evident in society such as Alzheimer's Disease and cancer. Weyand and Goronzy (2016, p.S422) state that old age comes with "declining protective immunity combined with increasing incidence of inflammatory disease", brought about from chronic energy stress. This change to the immune system as it ages could be called immunosenescence (see Figure 5).

IT DOES APPEAR THAT PRODUCTION IN THE BONE MARROW GOES DOWN, REDUCING THE AMOUNT OF T CELLS AND B CELLS

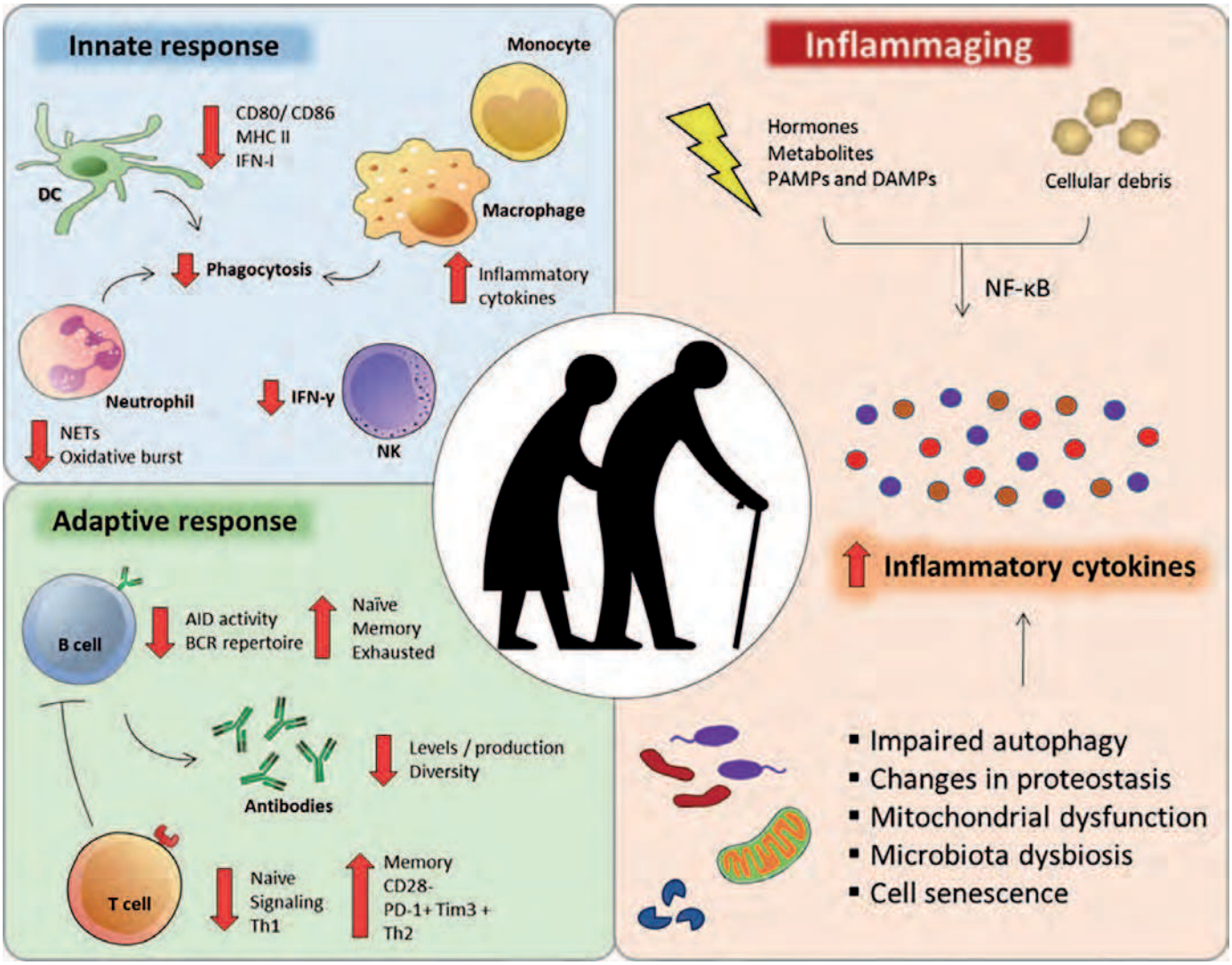


Figure 6 – Innate, adaptive responses and inflammaging

THIS THIRD PAPER HAS CONSIDERED FOUR MORE SYSTEMS OF THE HUMAN BODY AND HOW AGE AFFECTS THEM. IT IS CLEAR THAT THE OLDER PERSON HAS HEALTH CHALLENGES

NEUROENDOCRINE

The nervous and endocrine systems have strong relational elements but there are also some clear distinctions. Considering the nervous system first, Tortora and Derrickson (2011) suggest that brain growth, in particular the size of existing neurons, is most prolific in the first few years of life. As we reach early adulthood, brain mass reduces. The main difference is not in the number of neurons, rather focused on changes to the synaptic connections. This results in reduced conduction of messages and a consequential lessened ability to process information, changes to reflexes and the slowing down of voluntary movements. Cefalu (2011) agrees but adds further that the hippocampus itself reduces in size alongside the frontal and temporal lobes. This specifically contributes to the reduction in reaction time and changes in cognition, however added hormonal alterations can contribute to this as well (Sadavpu et al. 2004; Vaz Fragoso and Gill 2007).

In considering the endocrine system, Tortora and Derrickson (2011) suggest that the related glands generally shrink with age but this may or may not affect their performance. The thymus, for example, reduces significantly in size, but T cells are still produced despite this. There are, however, some age-related adjustments as outlined in Table 1.

CONCLUSION

This third paper has considered four more systems of the human body and how age affects them. It is clear that the older person has health challenges. Many of the adjustments to the working of the organs and tissues overlap with each and can significantly impact the individual in many different ways. This series of papers will continue by looking more specifically at the effects on the lower limbs and the possible fall-out from that in terms of everyday life and health support requirements.

Organ	Change	Consequences
Anterior-pituitary gland (produces somatotrophin)	Reduction in somatotrophin (growth hormone) secretion	Reduced protein synthesis Reduced lean body mass & associated metabolic rate Reduced bone mass and density Increased deposition of body fat
Pineal gland (synthesises melatonin from neurotransmitter serotonin)	Calcification in the older age and 80% reduction of melatonin in the blood from the age of 60	Lack of normal increased synthesis of serotonin at night resulting in sleep disturbances Possible geriatric insomnia with consequential change to cognitive function and age-related brain changes
Thyroid gland (production of T3 thyroxine and T4 triiodothyronine and calcium level control)	Reduced serum levels of T3 in conjunction with reduced thyroid stimulating hormone Changes to calcium homeostasis	Lowered metabolic rate and associated weight gain Reduced core temperature Changes to digestion, skin thickness and integrity Impact on bone density due to lack of osteoclast inhibition (NB possible changes compounded by gender)
Pancreas (release of insulin)	Insulin-producing beta cells less sensitive to glucose in the blood Decrease in insulin receptor cells Cell apoptosis with depletion	Risk factor for type 2 diabetes Reduced sensitivity to glucose triggers increase insulin release Cells less receptive to insulin create further pancreatic stimulation Excessive stress on the system
Adrenal glands (excretion of catecholamines, aldosterone, cortisol)	Reduction in adrenaline and noradrenaline however adrenaline remains constant due to reduced kidney function Reduction in aldosterone production Changes to cortisol production	Possible changes to sympathetic nervous system responses Changes to regulation of sodium and potassium plasma through altered osmosis Postural hypotension due to lowered blood volume and blood pressure Reduced bone density due to alterations in cortisol Changing cortisol resulting in cognitive decline, memory loss and sleep disorders (as well as alterations to the hippocampus itself)

Table 1- Changes in the Endocrine System
(based on Bubenik and Konturek 2011; Chahal and Drake 2007; Jonas et al. 2015; Knight and Nigam 2017a; Knight and Nigam 2017b; Miller 2009; Peeters 2008; Portale et al. 1997; Veldhuis et al. 2005; Wolf 2015)

REFERENCES

1. Abdullah, L. and Abbas, O. 2011. Common nail disorders in older people; diagnosis and management. Can Fam Physician. 57 (2). 173-181
2. Baran, R., Dawber, R.P.R. 1994. The nail in childhood and old age. In: Baran, R., Dawber, R.P.R., eds. Diseases of the nails and their management. 2nd ed. Oxford: Blackwell Science
3. Britannica. 2021. Human body. Encyclopedia Britannica. Available at: https://www.britannica.com/science/human-body (accessed 15.11.21)
4. Bubenik, G. A., Konturek, S.J. (011. Melatonin and aging: prospects for human treatment. Journal of Physiology and Pharmacology. 62 (1). 13-19.
5. Cavazzana. A., Röhrborn, A., Garthus-Niegel, S., Larsson, M., Hummel, T., Croy, I. 2018. Sensory-specific impairment among older people. An investigation using both sensory thresholds and subjective measures across the five senses. PLoS One. 13(8):e0202969. DOI:10.1371/journal.pone.0202969
6. Cefalu, C. A. 2011. Theories and Mechanisms of Aging. Clin Geriatr Med. 27. 491-506. Available at: doi:10.1016/j.cger.2011.07.001
7. Cefalu, C. A. and Nesbit, L. 2006. Common dermatological conditions in aging. In. Rosenthal, T., Naughton, B., Williams, M. (eds). Office care geriatrics. Philadelphia: Lippincott Williams & Wilkins
8. Chahal, H. S. and Drake, W. M. 2007. The endocrine system and ageing. Journal of Pathology. 211 (2). 173-180
9. Childs, B. G., Gluscevic, M., Baker, D. J., Laberge, R.-M., Marquess, D., Dananberg, J., et al. 2017. Senescent cells: an emerging target for diseases of ageing. Nat. Rev. Drug Discov. 16. 718–735. doi:10.1038/nrd.2017.116
10. Correia, C., Lopez, K.J., Wroblewski, K.E., Huisingh-Scheet,z M., Kern, D.W., Chen, R.C., et al. 2016. Global sensory impairment in older adults in the United States. J Am Geriatr Soc. 64 (2). 306–13. 10.1111/jgs.13955
11. Cossarizza, A., Ortolani, C., Paganelli, R., Barbieri, D., Monti, D., Sansoniand, P., et al. 1996. CD45 isoforms expression on CD4+ and CD8+ T cells throughout life, from newborns to centenarians: implications for T cell memory. Mech. Ageing Dev. 86. 173–195. doi:10.1016/0047-6374(95)01691-0
12. Decorps, J., Saumet, J.L., Sommer, P., Sigaudo-Rousse,l. D., Fromy, B. 2014. Effect of ageing on tactile transduction processes. Ageing Research Reviews. 13. 90–99. 10.1016/j.arr.2013.12.003
13. Doherty, T. J. 2003. Invited review: aging and sarcopenia. J Appl Physiol. 95. 1717-1727
14. Edwards, T., Yinnggang, Z., Ferrara, L. A., and Yuan, H. 2001. Structural Features and Thickness of the Vertebral Cortex in the Thoracolumbar Spine. Spine. 26 (2). 218-225
15. Fleming, D., Elliot, A.. 2005. The impact of influenza on the health and health care utilisation of elderly people. Vaccine. 23. S1–S9. doi: 10.1016/j.vaccine.2005.04.018
16. Franceschi, C., Bonafè, M., Valensin, S., Olivieri, F., De Luca, M., Ottaviani, E., et al. 2000. Inflamm-aging. An evolutionary perspective on immunosenescence. Ann. N. Y. Acad. Sci. 908. 244–254. doi:10.1111/j.1749-6632.2000.tb06651.x

Aging - Theories and Fall-Out

Notes:

17. Freund, A., Orjalo, A. V., Desprez, P. Y., and Campisi, J. 2010. Inflammatory networks during cellular senescence: causes and consequences. Trends Mol. Med. 16. 238–246. doi:10.1016/j.molmed.2010.03.003

18. Gates, G.A., Mills, J.H. 2005. Presbycusis. Lancet. 366(9491). 1111–20. Available from: http://www.sciencedirect.com/science/article/pii/S0140673605674235

19. Guo, S. and DiPietro, L. A. 2010. Factors affecting wound healing. J Dent Res. 89 (3). 219-229

20. Hamerman, D. 1998. Biology of the aging joint. Clin Geriatr Med. 14. 417-433

21. Haynes. L. 2020. Aging of the Immune System: Research Challenges to Enhance the Health Span of Older Adults. Frontiers in Aging. DOI: https://doi.org/10.3389/fragi.2020.602108

22. He, S., and Sharpless, N. E. 2017. Senescence in health and disease. Cell. 169. 1000–1011. doi:10.1016/j.cell.2017.05.015

23. Henderson, E. 2006. The potential effect of fibroblast senescence on wound healing and the chronic wound environment. Journal of Wound Care. 15 (7). 315-318

24. Henry, C. J., Marusyk, A., and DeGregori, J. 2011. Aging-associated changes in hematopoiesis and leukemogenesis: what's the connection? Aging. 3. 643–656. doi:10.18632/aging.100351

25. Hofer, A. C., Tran, R. T., Aziz, O. Z. et al. 2005. Shared phenotypes among segmental progeroid syndromes suggests underlying pathways of aging. J Gerontol A Biol Sci Med. 60. 10-20

26. Hummel, T., Kobal, G., Gudziol, H., Mackay-Sim, A. 2007. Normative data for the "Sniffin" Sticks" including tests of odor identification, odor discrimination, and olfactory thresholds: An upgrade based on a group of more than 3,000 subjects." Eur Arch Oto-Rhino-Laryngology. 264(3). 237–43

27. Iwamoto, T., Hanyu, H., Umahara, T. 2013. Age-related changes of sensory system. Nihon Rinsho. 71 (10). 1720-5. Japanese. PMID: 24261198

28. Jackson, M. J. 2009. Skeletal muscle aging: role of reactive oxygen species. Crit Care Med. 37 (10). S368-371

29. Jonas, M. et al. 2015. Aging and the endocrine system. Postepy Nauk Medycznych. 28 (7). 451-457

30. Keilich, S. R., Bartley, J. M., and Haynes, L. 2019. Diminished immune responses with aging predispose older adults to common and uncommon influenza complications. Cell. Immunol. 345. 103992. doi:10.1016/j.cellimm.2019.103992

31. Knight. J. and Nigam. Y. 2017a. Anatomy and physiology of ageing 7: the endocrine system. Nursing Times. 113 (8). 48-51

32. Knight. J. and Nigam. Y. 2017b. Diabetes management 1: disease types, symptoms and diagnosis. Nursing Times. 113 (4). 40-44

33. Lange, J. and Grossman, S. 2021. Theories of Aging. In. Mauk, K., Lange, J. and Grossman, S. Gerontological Nursing: Competencies for care. Burlington: Jones and Bartlett Learning

34. Lin, Y.H., Hsieh, S.C., Chao, C.C., Chang, Y.C., Hsieh, S.T. 2005. Influence of aging on thermal and vibratory thresholds of quantitative sensory testing. J Peripher Nerv Syst. 10 (3). 269–81. 10.1111/j.1085-9489.2005.10305.x

35. Linton, P. J., and Dorshkind, K. 2004. Age-related changes in lymphocyte development and function. Nat. Immunol. 5. 133–139. doi:10.1038/ni1033

36. McElhaney, J.E., Dutz, J.P. 2008. Better influenza vaccines for older people: what will it take? J Infect Dis. 198 (5). 632–634. doi: 10.1086/590435

37. Miller, M. 2009. Fluid balance disorders in the elderly. American Society of Nephrology online curricula: geriatric nephrology

38. Montecino-Rodriguez, E., Berent-Maoz, B., Dorshkind, K.2013. Causes, consequences, and reversal of immune system aging. J Clin Invest. 123 (3). 958-965. doi:10.1172/JCI64096

39. Mosekilde, L. 1993. Vertebral structure and strength in vivo and in vitro. Calcif Tissue Int. 53. S121-125

40. Nigg, B. M., Fisher. V., Allinger, T. L., Ronsky, J. R., Engsberg, J. R. 1992. Range of motion of the foot as a function of age. Foot Ankle. 13. 336-343

41. Nitz. J. C. and Low-Choy, N. 2004. The relationship between ankle dorsiflexion range, falls and activity levels in women aged 40-80 years. NZ J Physiother. 32. 121-125

42. O'Flaherty, E. J. 2000. Modeling normal aging bone loss, with consideration of bone loss in osteoporosis. Toxicol Sci. 55. 171-188

43. Owsley C. 2011. Aging and vision. Vision Research. 51. 1610–22. 10.1016/j.visres.2010.10.020

44. Parker, J. B. 1989. Active and passive mobility of lower limb joints in elderly men and women. Am J Phys Med Rehabil. 68. 162-167

45. Peeters, R. P. 2008. Thyroid hormones and aging. Hormones. 7 (1). 28-35

46. Pinto, J.M., Wroblewski, K.E., Huisingh-Scheetz, M., Correia, C., Lopez, K.J., Chen, R.C., et al. 2017. Global Sensory Impairment Predicts Morbidity and Mortality in Older U.S. Adults. J Am Geriatr Soc. 65 (12). 2587–95. 10.1111/jgs.15031

47. Portale, A. A. et al. 1997. Aging alters calcium regulation of serum concentration of parathyroid hormone in healthy men. American Journal of Physiology. 272. 139-146

48. Razzaghi, R., Pourbagheri, H., Momen-Heravi, M., Bahmani, F., Shadi, J., Soleimani, Z., and Asemi, Z. 2017. The effects of vitamin D on wound healing and metabolic status in patients with diabetic foot ulcer: A randomised, double-blind, placebo-controlled trial. J Diabetes Complications. 31 (4). 766-772. DOI: 10.1016/j.jdiacomp.2016.06.017.

49. Reichert, T., Simonsen, L., Sharma, A., Pardo, S., Fedson, D., Miller, M. 2004. Influenza and the winter increase in mortality in the United States. Am J Epidemiol. 160 (5). 492–502. doi: 10.1093/aje/kwh227

50. Sadavpu, K. et al. 2004. Comprehensive textbook of geriatric psychiatry. 3rd ed. New York: WW Norton and Co

51. Seals, D. R. and Esler, M. D. 2000. Human aging and the sympathoadrenal system. Journal of Physiology. 528 (3). 407-417

52. Seubert, J., Laukka, E.J., Rizzuto, D., Fratiglioni, L., Bäckman, L., Larsson, M., et al. 2017. Prevalence and Correlates of Olfactory Dysfunction in Old Age: A Population-Based Study. 00 (00). 1–8

53. Singh, G., Haneef, N.S., Uday, A. 2005. Nail changes and disorders among the elderly. Indian J Dermatol, Veneveol Leprol. 71. 386–392

54. Thompson, W. 2003. Mortality associated with influenza and respiratory syncytial virus in the United States. JAMA. 289 (2). 179–186. doi: 10.1001/jama.289.2.179

55. Tortora, G. J. and Derrickson, B. 2011. Principles of Anatomy and Physiology. Hoboken: John Wiley & Sons Ptd Ltd

56. Vaz Fragoso, C. A. and Gill, T. M. 2007. Sleep complaints in community-living older persons: a multifactorial geriatric syndrome. J Am Geriatr Soc. 55. 1853-1966

57. Veldhuis, J. D. et al. 2005. Joint mechanisms of impaired growth-hormone pulse renewal in aging men. Journal of Clinical Endocrinology and Metabolism. 9 (7). 4177-4183

58. Vina, J., Borras, C., and Miquel, J. 2007. Critical Review: Theories of Ageing. IUBMB Life. 59 (4-5). 249-254

59. Weyand, C.M., Goronzy, J.J. 2016. Aging of the Immune System. Mechanisms and Therapeutic Targets. Ann Am Thorac Soc. 13. Suppl 5. S422-S428. doi:10.1513/AnnalsATS.201602-095AW

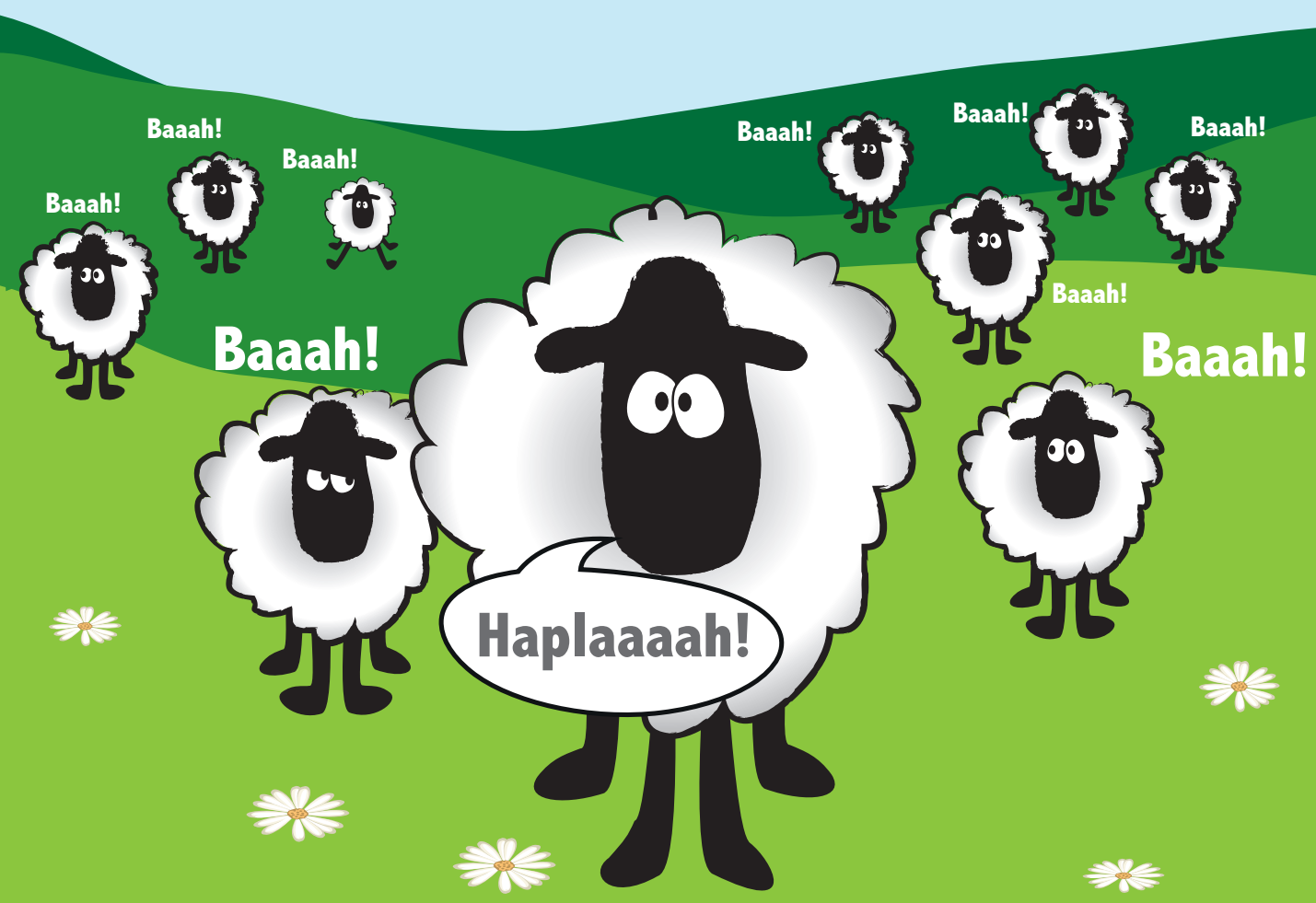
60. Yanagishita, M. 1993. Function of proteoglycans in the extracellular matrix. Pathology International. 43 (6). 283-293

Stand out in your field with Hapla...aaah!

Hapla choose only the finest grade wool for their felts with minimal medulla core structure to ensure ideal pressure re-distribution and absorption behaviour... aaah!

Hapla maintain tight control on wool staple length. This ensures consistent bonding of wool fibres, minimises delamination and maintains a soft and comfortable felt bed... aaah!

All with our clinically proven adhesive only from **Hapla**... aaah!



For more information visit:

www.hapla.co.uk

Cuxson Gerrard & Co. Ltd., Broadwell Road, Oldbury, West Midlands B69 4BF, UK.

Classifieds

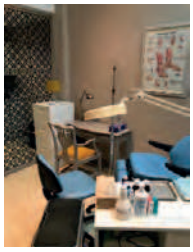
For Sale, Wanted and Services

Advertising Deadline

Post or email your advertisements to Carol O'Brien at COBrien@smaeinstitute.co.uk by 6th June 2022

Professionals Wanted

Foot Treatment Rooms



Opportunity to rent foot treatment rooms in two prime areas of Cheltenham. Ideal for a freelance chiropodist or FHP. Well fitted premises have sinks and storage. Equipment includes Motorised podiatry chairs, one 5 motor the other 1 single motor, Bechtold workbenches, Luxo magnifying lights and Hadewe dust extraction drills. Excellent earning potential. Days are negotiable.

Call 077196 37414 for more information.

Surgery Equipment for sale (Kent/SE London)

Due to retirement. Various items including patient chair, workstation, autoclave, clippers etc.

Email sallyjohnston76@gmail.com

Practice for sale or lease

I am looking to either sell my practice or lease to newly qualified practitioners who want to start out quickly.

£130K turnover 2 fully equipped rooms

Email : info@ketteringfoothealth.co.uk
Telephone : 07976361572

Foot Health Professional Required

(Coulsdon, CR5 2NF, Surrey)

Foot Health Professional required to help with our well established home visiting service. In clinic work also available. Shared fees, self-employed basis. Friendly, supportive clinic. For further information phone 020 8660 0349. Please email your CV:

Email: thefoothealthcentre@gmail.com

Foot Health Professional Required (Hampshire)

Sheridan Foot Heath was formed in 2013 and offers services across two busy clinics in Portchester and Locks Heath (Hampshire)

We are now looking to grow the team and looking for a part time Foot Health practitioner to work in our established professionally run Foot Health clinics.

- Part-time hours available 2/3 days per week
- Access to Clinical support.
- Established Client base
- Full Induction programme available for new starters.

To find out more about the services offered, please visit **www.sheridanfoothealth.co.uk**

Please submit your CV and any enquiries to **disheridan9@gmail.com**

Sheridan Foot Health
Give foot problems the boot

Members' Zone

Reader's Letter

"I had to say what another great copy of the Podiatric Medicine Journal having recently received the Autumn edition. Very high-quality presentation with many interesting articles. As usual, I enjoy Andrew Hill's contribution, which was on one of my pet subjects – pharmacotherapy, and of course, did podiatry training cover the subject sufficiently in past, no matter what the teaching authority was? It is fair to say that Andrew's articles over the past few years has done much to remedy this, and this month's subject was extremely useful to all Smae members."

Clive Vernon

CONTINUAL PROFESSIONAL DEVELOPMENT

www.smaecpd.com

Workshop Format

virtual (zoom) and in-house

in-house only

Whilst many have enjoyed the new virtual workshops we have put in place, there are some members that would prefer to attend workshops in-house. For this reason, we are delighted to continue offering the majority* of our workshops virtually via Zoom, or in-house - the choice is yours! When booking a place you simply need to let us know your preference of in-house or virtual and you will be booked on accordingly.

** The hands-on workshops can only be attended in-house.*

THE SMAE INSTITUTE

Visit the Smae CPD website where you can find more details about our workshops, CPD@Home range and our annual CPD events!

You can also download booking forms for these events and access your online CPD subjects.

Ever considered teaching in the foot health field? If so, then we would love to hear from you!

Contact Andrew Hill at ahill@smaeinstitute.co.uk

The Institute reserves the right to postpone and reschedule lectures. Fees paid are non refundable or transferable.

SUMMER SCHOOL IN THE FALL - 7TH & 8TH OCTOBER 2022

Workshops

Workshop Format

Many of our workshops can now be attended either virtually via Zoom or in-house, the choice is yours! When booking a place you simply need to let us know your preference of in-house or virtual and you will be booked on accordingly.
** The hands-on workshops can only be attended in-house.*

virtual (zoom) and in-house

in-house only

Medical Emergency Procedures Courses

Sunday 15 May Fully Booked
Sunday 29 May Limited Places
Saturday 11 June
Sunday 12 June
Sunday 3 July

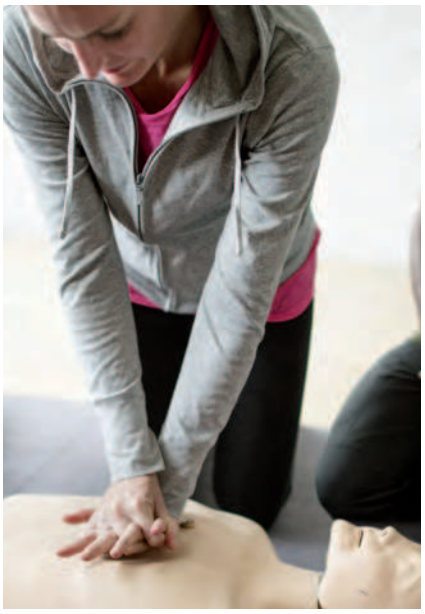
In keeping with safety in Foot Health practice, it is essential that every clinician undertakes medical emergency training every 3 years. To help facilitate this, the Institute runs an in-house bespoke training day to fulfil this requirement.

The day is fun, informative and relevant to the clinical situation. It is also a great opportunity to network with like minded professionals.

The Medical Emergency Procedures day covers amongst other things:

- Carrying out emergency procedures single handed including basic life support / CPR
- Principles of recognition of collapse, diagnosis, treatment and referral
- Coping with medical emergencies including the unconscious patient and respiratory and circulatory disorders
- A basic overview of minor injuries

Cost: £110.00
(A certificate is provided upon satisfactory completion)



Biomechanics Level 1

A Beginners Guide

18th & 19th May 2022
10.00am - 4.30pm
Lecturer: Andrew Hill

A 2 day introduction into the world of biomechanics including functional lower limb anatomy, common biomechanical foot complaints and how to manage them, pedorthic examination, and comprehensive assessment of the foot & ankle. Run as a Step-by-Step hands on workshop aimed at practitioners wishing to add another lucrative dimension to their clinical skills.

Cost: £289.00

Biomechanics Level 2

A Focus on Pathology

20th & 21st July 2022
10.00am - 4.30pm
Lecturer: Andrew Hill

A 2 day hands on workshop focused on further exploration of lower limb anatomy, biomechanics and pathomechanics including assessment of the knee and hip, leg length discrepancy, static and dynamic weight bearing examination and concepts of human motion.

NB: Successful completion of biomechanics Level 1 is a prerequisite for this course.

Cost: £289.00

Biomechanics Level 3

Therapeutic interventions & Prescription writing

14th & 15th September 2022
10.00am - 4.30pm
Lecturer: Andrew Hill

A 2 day hands on workshop focused on consolidating patient centred assessments of the foot, ankle, knees and hips, as well as comprehensive gait analysis. It includes interpretation of all findings in the context of insole and orthotic prescription writing; including how to take templates or casts, and how to correct any identified pathomechanics of the lower extremities. On completion, the practitioner will have the knowledge and skill to confidently incorporate biomechanics into their practice.

NB: Successful completion of biomechanics Levels 1 & 2 are a prerequisite for this course.

Cost: £289.00

Fungal Infection of the Skin and Nails – can you recognise it?

3rd May 2022

10.00am - 4.30pm

Lecturer: Belinda Longhurst

This presentation identifies which organisms are responsible for both tinea pedis and onychomycosis and how to take appropriate tissue samples for microscopy and culture, as well as clinical testing for dermatophytosis. We examine the evidence base for treatments and discuss patient and species specific treatment plans for what is the most common skin condition of the foot.

Cost: £56.00

Dementia – How best to manage this identity thief?

10th May 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

MEMBERS FAVOURITE

Dementia is an ever-increasing mental health condition that requires all manner of specialist care and attention. As a practitioner having to provide foot treatment to somebody with dementia there can be a whole host of scenarios and situations in which you feel underprepared. This workshop is designed to explore dementia to help the practitioner gather an understanding of the condition as well as discussion and focus on how to manage potentially troublesome situations.

Cost: £56.00

Referral Pathways – when to involve the GP or the Multi-disciplinary team

24th May 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

All practitioners encounter patients that they need to refer on, but there isn't an exact science to determine who and when the referral should be made. This workshop looks to explore both acute and sub-acute clinical situations in which referral may or may not be necessary and looks into the most appropriate course of action a practitioner should take in such situations which aims to clear up elements of doubt or confusion.

Cost: £56.00

What is so important about my Patients' medication?

7th June 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

A vast majority of patients who come to have their feet treated by a professional will be on some form of medication. As medicines work by inducing chemical reactions in the body, it is no surprise that there are many side effects associated with a patient's medication. These side effects can be responsible for a lot of pathologies in patients and their feet, as well as masking other underlying problems.

It is the aim of this workshop to provide a basic overview into the most common medicines being taken by patients and the reason why they are taking them. The workshop aims to outline the side effects of these medications and how they implicate podiatric practices.

Cost: £56.00

Skin and nail recognition conditions – an introduction to dermoscopy

17th June 2022

10.00am - 4.30pm

Lecturer: Belinda Longhurst

A day of improving dermatological assessments and lesion recognition skills via history taking, visual clues and further investigations to improve patient outcomes. The day includes an introduction to using a dermatoscope in clinical practice and formulating appropriate referral pathways for suspicious lesions.

Cost: £56.00

What makes a foot 'High Risk'?

5th July 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

Many conditions commonly encountered in the population render the foot 'high risk'. This particular focus is often centred on the development and management of chronic wounds that can and do occur in the foot.

This workshop will identify and look at the various conditions that mark the foot as being 'high risk' and will look at the development of chronic wounds in these conditions. There will also be an exploration of the various treatment modalities currently advocated for wound management. The relevance to private practice will also be discussed.

Cost: £56.00

How does Parkinson's affect the patient and their feet?

19th July 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

Parkinsonism is a common condition found in the older population. Whilst it is not a disease that primarily attacks the feet, the neurological nature of the condition can certainly impact upon the feet and compound the debilitating nature of the later stages of the condition. This workshop looks holistically at Parkinsonism and considers the pedal impact for both the patient and the practitioner.

Cost: £56.00

Verrucae & Tumours

MEMBERS FAVOURITE

Recognition and Management

9th August 2022

10.00am - 4.30pm

Lecturer: Belinda Longhurst

This presentation is a refresher on the aetiology of verrucae and other benign, pre-malignant and malignant tumours we encounter in practice. We examine the evidence base of treatments and discuss practitioner assessments along with timesensitive referral pathways for those which require further investigation.

Cost: £56.00

Fostering Improvements in Patient Health Behaviour

12th August 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop is aimed at Podiatrists and FHPs who spend time (or need to spend time) encouraging patients to consider behaviour change as a means to manage their condition(s) more optimally. Whilst this is a growing 'ask' of all health professionals to help encourage healthy and positive behaviours in patients, it is not something that they are collectively trained to do in any meaningful way. Accordingly, there is often a communication breakdown that ensues from this (well intentioned) attempt to influence a patients behaviour. This workshop is designed to help you start addressing communication in the context of promoting behaviour change in patients. It will introduce concepts related to reasons underpinning patient decision-making; ambivalence; your role as a communicator and tie all of this together in the context of motivational interviewing as a technique to improve this aspect of growing importance in clinical practice.

Cost: £56.00

Podopaediatrics

How would you deal with a Child's Foot Problem?

31st August 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

The child foot encounters large amounts of change as it grows and adapts to the environment. During these formative years, the foot can be at its most vulnerable as it is having to take the load of the whole body as well as changing its shape and size. Therefore any extra stresses or pressures can have long-term and potentially serious effects.

The field of Podopaediatrics is one that explores the natural development of the foot as well as any pathological conditions that are commonly found in children's feet. Podopaediatrics is a specialist area as the child foot and the adult foot are vastly different, and so treatment options for adult's feet are not always directly transferable into the child foot. This workshop is designed to help you in practice to identify foot pathologies in children, and undertake appropriate treatment regimes for them.

Cost: £56.00

What is the best way to deal with Onychocryptosis?

1st September 2022

MEMBERS FAVOURITE

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop provides a more in-depth look into ingrowing toenails. It will provide confidence to identify different presentations of Onychocryptosis as well as give practical experience in treating the condition. The course will outline conventional treatments as well as alternative ones (such as scalpel and beaver blade use). Referral pathways and surgical interventions will also be explored. The practical session will be practiced on prosthetic toes.

Cost: £56.00

What is that persistent pain in the ball of the foot?

Exploring Metatarsalgia

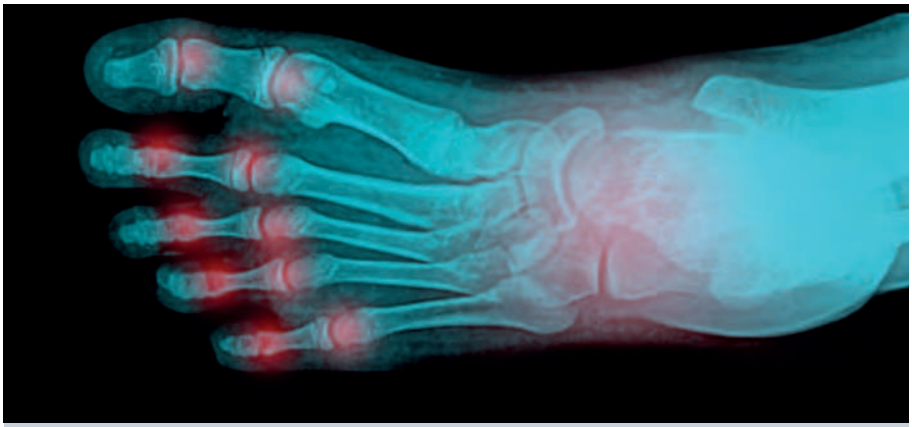
8th September 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

An umbrella term used to describe generalised forefoot pain. Whilst extremely common, the causes of Metatarsalgia are extremely varied and correctly diagnosing the cause is half of the battle when looking to relieve the pain. This workshop comprehensively covers each established cause of Metatarsalgia and discusses diagnosis and management of each of them. Ideal for practitioners new and experienced alike!

Cost: £56.00



What Type Of Joint Problem Does Your Patient Have?

27th September 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

The arthritides cause sufferers chronic pain and make daily tasks difficult. This workshop looks at these conditions, and how we as practitioners can provide relief to the pain that these conditions can cause the feet.

We will look at:

Rheumatoid Arthritis

- RA and pathogenesis / epidemiology
- Process of synovial inflammation and progression to erosive arthritis
- Treatment / general principles / flowchart including DMARDS
- Particular problems of RA with respect to ulceration, vascular disease and infection
- Deformities and biomechanical problems associated with RA

Other Rheumatological / Inflammatory Problems and other arthritides

- Other forms of arthritis and its management
- Metatarsalgia in more detail and its various causes (other than RA)
- Ankle and mid-tarsal problems
- Achilles tendonitis and Bursitis
- General advice with respect to exercise
- Patient advice and information sheets,useful sources e.g. ARC

Cost: £56.00

Heel Pain – is it just another case of Plantar Fasciitis?

6th October 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

Heel pain is an all too common complaint for a number of people with terms like 'Policeman's heel' and 'heel spurs' being widely used by the general public. In more recent years, a greater public awareness of 'Plantar Fasciitis' has emerged meaning that not only are patients self-diagnosing (often erroneously) but also a great many practitioners are too quick to assume that any heel pain is plantar fasciitis. This workshop looks into what is occurring in the heel anatomically and how these structures can lead to pain development when they become injured or malfunction. It is hoped that this can lead to more accurate diagnosis and treatment regimes accordingly.

Cost: £56.00

Are you promoting evidence-based practice?

3rd November 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop will look at the importance of evidenced-based practice and how this feeds into rationale and decision making in a clinical context. It will also consider the effect of dangerous claims and look at treatment myths that can have bad outcomes for you and your patients.

Cost: £56.00

The Sharp End of the Job

Scalpel Debridement & Enucleation Technique

19th October 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

In this workshop we will be looking at the anatomy of the skin, epidermal and dermal tissue, and its relation to the development of callus and of various heloma formations.

This workshop will present how to assess and treat callus and helomas, focusing on scalpel debridement and introducing an effective method for heloma enucleation using the scalpel 15T blade. The morning session will be based on theory, with the afternoon being a practical session on scalpel debridement with heloma enucleation on artificial corns.

Cost: £56.00

Tropical Diseases of the Foot

1st December 2022

10.00am - 4.30pm

Lecturer: Andrew Hill

Given that in today's society people can travel the world quickly and relatively easily – it is plausible that foot conditions of a curious origin could well be encountered within the UK. It also takes an interesting look at how our podiatric colleagues in different parts of the world face different challenges that we do in Western Europe.

This workshop will look at the various foot conditions that can be encountered that do not have a common domestic cause. Many conditions will be explored in how virulent bacterial strains can cause all manner of serious foot problems.

Cost: £56.00

Common Foot Conditions

Things that you cannot afford not to know about

15th November 2022

10.00am - 4.30pm

Lecturer: Debbie Rockell

This workshop provides the practitioner with the general conditions that present at their practice. The conditions that will be discussed will range from various basic dermatology conditions, neurological conditions, vascular conditions and musculoskeletal disorders. It is a great refresher course and can direct the practitioner into desired fields.

Cost: £56.00

How Would You Look After A Patient With Chronic Pain?

13th December 2022

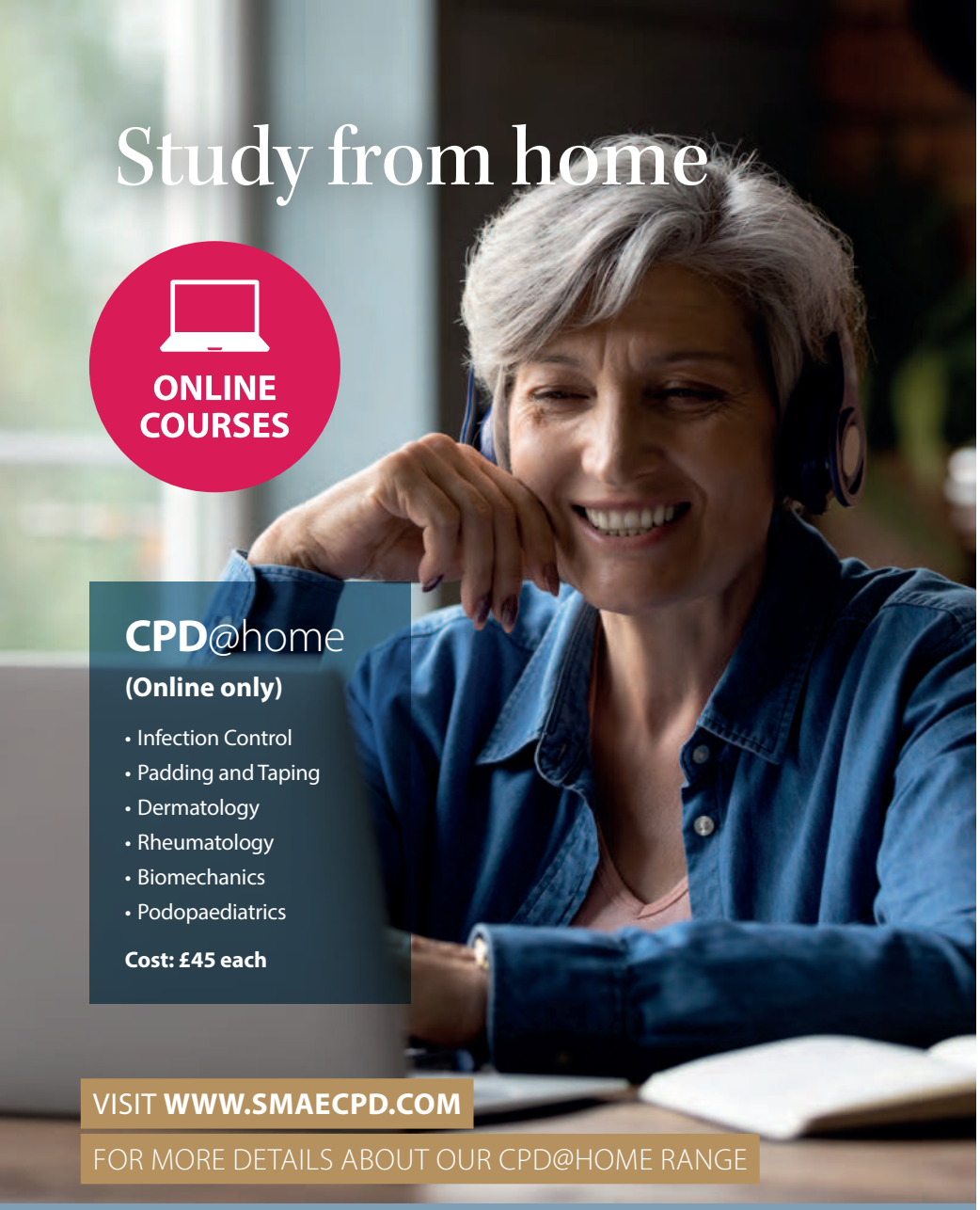
10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop is designed to explore the concept of chronic pain and its management. A variety of chronic pain conditions will be discussed and differences between the types of pain will be explored.

This session will look at not only the pharmacological and alternative methods of pain relief, but also how this impacts your patient and your treatments for these patients.

Cost: £56.00



Fostering improvements in patient health behaviour

(Online only)

With a changing landscape of public health comes a change in the way that healthcare is delivered and received. In more recent years, healthcare professional across a wide number of disciplines have been moving away from a more traditional, didactic view of the patient-practitioner relationship towards notions of concordance and equity of decision making between both parties.

This change of direction, whilst far from complete, has re-defined the way in which healthcare professionals might best deliver their care within the context of facilitating behaviour change in patients and changing the mind-set away from considering a patient as 'adherent' / 'non-adherent' or 'compliant' / 'non-compliant'. This is particularly true in the delivery of healthcare for patients with more chronic health conditions in which altered lifestyle and amended behaviours are a cornerstone of disease management. As perspectives on healthcare delivery change, the emergence of different approaches towards delivering care to the patient is a logical consequence.

This CPD aims to explore patient-practitioner relationships and how we can improve our consultation skills to best help patients to to make beneficial decisions about their health and to foster any change in behaviour for the longer term.

Cost: £45.00

The On-Going Challenge of Ulcer and Wound Management

(Online only)

Ulcers and wounds are a large problem facing many individuals who are 'at risk'. Identifying the risk factors can certainly help to reduce the incidence and impact of these debilitating lesions. This CPD looks to address what a practitioner should do when encountering a wound or ulcer and help to alleviate the apprehension and fear that a practitioner may otherwise face by arming them with information and guidance.

This CPD covers:

- Structure and function of the skin
- Concept and issues of tissue viability
- The 'high-risk' patient
- Prevention of wound development and complications
- General considerations for treating high-risk patients
- Examining the wound
- Identifying and treating infection
- Osteomyelitis
- Treating the wound
- Dressings
- Other aspects of wound management
- Conclusions

Cost: £45.00

Tackling the Nerves

(Online only)

The nerves are a crucial part of our anatomy and neurological disorders in the lower extremity result from disease processes that involve sensory, motor and autonomic nervous systems. This can follow a metabolic or hereditary process or indeed an injury or trauma which can create progressive or static deformity and be treatable or incurable. Any process which impacts on the delicate nervous tissue and its ability to process electrical signals can create significant issues within the body, not least the lower limb. This CPD looks to assess the nervous system and tackle nervous system pathologies to help practitioners in their management of patients with neurological disorders.

Cost: £45.00

Anatomy, Cell Biology and Physiology Series

The Endocrine System

(Online only)

The endocrine system is made up of a network of glands. These glands secrete hormones to regulate many bodily functions, including growth and metabolism. Endocrine diseases are common and usually occur when glands produce an incorrect amount of hormones or when the hormones cease to work effectively. Thus, when these diseases occur many –if not all- body systems can be adversely affected leading to many life-altering, and possibly life threatening, outcomes. This CPD seeks to explore the main principles and anatomy and physiology of the endocrine system with a focus on pathology and management of endocrine disorders.

Cost: £45.00

The Cardiovascular System

(Online only)

Anatomy, cell biology and physiology are key and underpinning subject areas for all health disciplines. Understanding the way that the body works on both the micro- and macro scale allows us not only understand normal physiological function, but also to understand pathology of various body systems and how medicinal approaches can remedy these pathologies. Within this series of CPD subjects, this one in particular focuses on the Cardiovascular System.

Cost: £45.00

The Respiratory System

(Online only)

The respiratory system contributes to homeostasis by facilitating the exchange of gases – oxygen (O_2) and carbon dioxide (CO_2) – between the atmospheric air, blood and tissue cells. It also plays a role in adjusting the pH of body fluids. Oxygen is the single most important substance that our body requires. Without it death would occur in minutes. Therefore, the importance of the respiratory system is evident and when it doesn't work properly there are serious health implications. This CPD covers the anatomy and physiology of the respiratory system to provide context to help explain and understand respiratory conditions and how they affect the whole body.

Cost: £45.00

What is that pain in the foot my patient is complaining of?

(Online only)

Pain across the metatarsal region of the foot is very common, yet pinning down exactly what is causing it can be tricky. The term 'metatarsalgia' is used to describe such pain but this term only describes the symptoms - pain in the metatarsal region of the foot. This CPD looks to explore this area of the foot both anatomically as well as pathologically and covers the various conditions that can given rise to pain in the ball of the foot. This CPD is ideal for new and experienced practitioners alike and will help support and direct clinical assessments and treatments of this all too common problem.

Cost: £45.00

Can you avert a potential disaster?

Managing the foot in Diabetes

(Online only)

With diabetes mellitus consuming 10% of the entire NHS budget for England and Wales and a significant portion of that amount (some £300m) being spent on managing avoidable foot-related complications, there is a considerable focus on developing tools and strategies to minimise both the individual and financial cost of this devastating disease. The role, therefore, that podiatrists and foot health professionals play in the reduction of morbidity and mortality of the disease as well as improving patients' quality of life cannot be overstated. Against this backdrop this CPD will discuss diabetes mellitus from pathophysiology through to complications and implications for practitioners.

Cost: £45.00

Treating the Persistent Verruca CPD

(Online only)

BEST SELLER

This CPD tackles the area of patient Verrucas are one of the most common conditions treated by podiatrists and FHPs. Sometimes they resolve quickly and very often spontaneously. However, there is a large number that take many months (if not years) to resolve. These lesions are what are termed 'persistent verrucas' and successful treatment of them can be elusive.

This CPD explores this condition from pathophysiology of the condition through to the treatment modalities available to the patient. This serves as a useful guide to practitioners looking to keep up to date with treatment options (standard and contemporary) as well as providing theoretical interest for those looking to broaden their understanding of this common condition.

Areas covered include:

- Overview and Background of Verruca Pedis
- Types of Verruca
- Structure and function of skin
- Clinical Features
- Treatment options:
  - Sharp debridement + occlusion
  - Caustic treatment
  - 'Natural remedies'
  - Cryotherapy
  - Laser Treatment
  - Bleomycin
  - 'Needling'
  - Surgical intervention
- Patient suitability and prognosis

Cost: £45.00

Tropical Diseases of the Foot

(Online only)

This CPD looks to introduce various pathologies that have traditionally been encountered in foot health and Podiatry clinics within tropical climates. It is the responsibility of the modern and competent practitioner to identify certain tropical diseases of the foot and at least have a rudimental understanding of them and their treatments given that more round the world travel is ever more common meaning that more and more of these conditions are being seen more frequently in temperate climates – certainly including the UK.

Cost: £45.00

Common Conditions Affecting The Elderly

BEST SELLER

(Online only)

Elderly patients make up a very large proportion of our clients. It is also this demographic of patients who tend to have more underlying pathologies and chronic foot problems. The elderly foot, therefore, can present in many different ways and provide a complex set of challenges. This CPD will discuss the symptoms and treatments of various pathologies that are commonly seen in the elderly foot.

Conditions that will be discussed include:

- Arthritis
- Parkinson's Disease
- Peripheral Vascular Disease
- Peripheral Neuropathy
- Common Biomechanical pathologies in the elderly foot
- And many, many more

Cost: £45.00

Is It Fungal Or Isn't It?

BEST SELLER

A guide to this most common of Skin and Nail Pathologies

(Online only)

The presentation of a fungal infection in the skin and / or nails is often considered easily distinguishable – however, as this CPD will explore, that is often far from the case with many fungal infections incorrectly labelled as being something else entirely, or a fungal infection going undiagnosed for long periods of time. This certainly can render treatments ineffective, which makes the already tricky task of effective treatment all the more complicated.

This CPD looks to cover all this and more:

- Structure and function of the skin
- Structure and function of the nails
- Types of fungal infection
- Fungal infection of the skin
- Fungal infection of the nails
- Prognosis and future considerations

Cost: £45.00

Are you performing vascular assessments properly?

(Online only)

Vascular assessments are a crucial part of the patient appointment, but are significantly devalued if they are not being done regularly or correctly. The aim of this CPD program is to improve the diagnostic skills of practitioners in their assessment of the vascular system.

By applying more evidence-based actions to their clinical practice, the benefits to patients are significant. This is a must-do CPD for practitioners to ensure that they are providing excellent care for their patients.

Cost: £45.00

Commonly Used Medications And Their Side Effects

BEST SELLER

(Online only)

The aim of this CPD is to educate the practitioner in the effects, both adverse and otherwise, of common medicinal interventions for equally common conditions. This CPD will go on to explore how these effects will influence the symptoms of your patients foot problems as well as the treatments that can be offered.

Cost: £45.00

Are you a Modern Practitioner?

The Growing Need for Health Promotion & Patient Education

(Online only)

This CPD tackles the area of patient education and health promotion. It is easy for health professionals to slip into an isolated view of themselves in the context of their patients' overall health and the role that they may play in improving that.

Certainly within the context of many widespread and serious health conditions such as diabetes mellitus, concepts of 'patient empowerment' and patient-led management is a recent paradigm shift. As such, modern day Podiatrists and FHPs need to take a significant role in the multidisciplinary approach to healthcare. The CPD looks to discuss this theory and provide some useful and insightful guidance on this growing and changing landscape.

Cost: £45.00

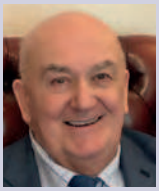
VISIT **WWW.SMAECPD.COM**

FOR MORE DETAILS ABOUT OUR CPD@HOME RANGE

British Chiropody & Podiatry Association

The British Association of Foot Health Professionals

REGIONAL BRANCHES & CONTACT DETAILS



Hon. President

Michael J. Batt
info@smaeinstitute.co.uk
Tel: 01628 621100

The SMAE Institute (1919) Ltd,
The New Hall, 149 Bath Road,
Maidenhead, Berkshire SL6 4LA

Chairman of BCPA / BAFHP

Deborah Mercer FSSCh MBChA
chairman@bcpa-uk.org
Tel: 01268 741019 / 07932 928113

120 Bull Lane, Rayleigh, Essex SS6 8NQ

East Anglia Branch

Chairman: Alex Hepburn
alexhepburn30@hotmail.com

Treasurer: Deborah Hart
deborahhartuk@yahoo.com

Venue: Honington and Sapiston Village Hall,
Bardwell Road, Sapiston, Bury St Edmunds,
Suffolk, IP31 1RU | 9am – 1:30pm

East Midlands Branch

Chairman: Ruth Cranmer
ruth.cranmer@feetaid.co.uk

Secretary: Carl Eary

Treasurer: Toni-Maria Walter

Venue: The Cedars Hotel & Restaurant,
Cedar Road, Loughborough.
LE11 2AB | 10am – 1pm

Essex & East London Branch

Chairman: Deborah Mercer FSSCh MBChA
deborah.mercer2@btinternet.com

Secretary: Anna Mapp
anna.mapp773@gmail.com

Venue: Bulphan Village Hall, Church Road,
Bulphan, Upminster, Essex RM14 3RU
1:30pm – 4:30pm

Kent Branch

Chairman: Emma Thorpe
emmathorpefoothealth@gmail.com

Secretary: Heather Callaghan
heathercallaghan66@gmail.com

Venue: Davis Estate Community Centre,
Barberry Avenue, Chatham, Kent ME5 9TE
9am – 12noon

North West Branch

Chairman: Christopher Hunter
Christophe0@aol.com

Secretary: John Gobin
Jgobin@hotmail.com

Minutes Secretary: Angela Fenton
angela_fenton@hotmail.co.uk

Venue: Ormskirk Civic Hall, Southport Road,
Ormskirk L39 1LN
10am – 2pm

Scottish Branch

Chairman: Lorna Stronach
lornastronach999@gmail.com

Secretary: Fiona Morgan
fiona.morgan22@btinternet.com

Venue: Diocese of Dunkeld,
24-28 Lawside Road, Dundee DD3 6XY
1pm – 3pm

South East Branch

Chairman: Marianne Elliott
thehappyfootcompany@icloud.com

Secretary: Verity Nicholls

Treasurer: Kate Alexander
kate.alexander1@hotmail.co.uk

Venue:: The Crowne Plaza Felbridge Hotel, London Road, East Grinstead. RH19 2BH
9am – 4pm

South West Branch

Chairman: Jayne Chudley
jaynechudley1@gmail.com

Secretary: Katharine Hardisty
katharinehardisty@yahoo.co.uk

Venue: St. Cuthbert's Conference Centre, Buckfast Abbey, Northwood Lane, Buckfast, Devon TQ11 0EG
9am – 5pm

West Midlands Branch

Chairman: Eléna Serafinas Broom
elenapodiatry@hotmail.com

Secretary: Emma Jones
completelyfeet@hotmail.com

Venue: Aldridge Community Centre, Anchor Meadow, Middlemore Lane, Aldridge, Walsall, West Midlands WS9 8AN
12noon – 4pm

The Benevolent Fund

Elaine Hale
e_hale@hotmail.co.uk

Michelle Leadley
frostm69@hotmail.co.uk

Katharine Hardisty
katharinehardisty@yahoo.co.uk

Supplying the professional

Members' Exclusive Offer!

5% OFF

Everyday items. Exceptional savings.

BladeFlask - Blade Removal Box with Mounting Bracket

T4590 ~~RRP £30.99~~ **Offer Price £29.44**

Remove, contain, and dispose of scalpel blades in one click. Secured using a reusable mounting bracket (included). Quickly and safely remove up to 100 blades at the point of use.

Features

- Single-handed blade removal
- Shuts off after maximum capacity is reached (100 blades)
- Puncture-proof sharps container

Order online at **www.podiacare.co.uk** and enter code **'BFLASK22'** at checkout or call us on the number below

Telephone
01628 632 449

Answerphone
01628 637 625

Email
orders@podiacare.co.uk

PODIACARE HEALTHCARE
Manufacturers of Footcare Products, Instruments and Medical Equipment

Prices exclude VAT. Offer expires 31/05/2022.