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For the Private Practitioner

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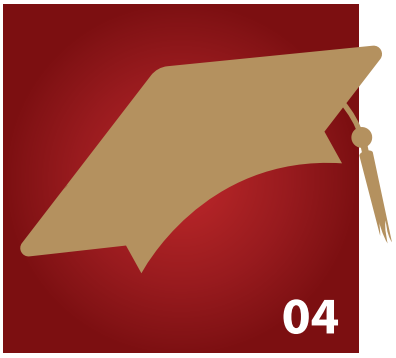

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Editorial

THE SMAE INSTITUTE

2020 will be remembered as a most unusual year heralded with the worries of Covid-19. The uncertainties it has caused have given so much concern to so many people. Nevertheless, we all must work together and overcome these problems which are purely transient, and 2021 should be a better year.

We had a fantastic 2019 with the celebration of one hundred years of the SMAE institute, and of course we always feel concerned about any change other than going forwards. Be that as it may, the excellent news we have for the coming year is that we now have approval (subject to conditions being met) for the BSc honours in Podiatry, with our collaborative partner the Queen Margaret University in Edinburgh, who are a joy to work with. A great deal of praise must be given to Derek Kayanja, and of course the whole team who have made this all work so well for us all. Nevertheless, we must not be complacent, we must move forward and that is what we shall be doing.

It was very sad not to be able to have our Summer School and our Convention at our usual places, but we hope that these two events will be fully restored in 2021, and we are all working in that direction. When you look at the hotels they must have suffered terribly during this pandemic, and of course this is a concern for them, their staff and all the other hospitality organisations. The most vulnerable group are the elderly as you know, and some of us fall into that category! We must all be positive and move forward as we shall. For those of us who are slightly fading, it may help to remember that World War 2 was far worse at its height and yet we got through. Remembering having to go to sleep with the fear of bombs falling all around you, and thinking that they would probably not hit you, and if they did you would not remember. So let us look forward to the future and let us all work hard to make certain it is a positive future, which it will be if we go about it the right way, and may we here at Maidenhead thank all the staff for what they have done, in working in difficult circumstances and we look forward, very much, to the future.

We wish you and your families a very happy and peaceful Christmas and a really good New Year.

By Mike Batt

BSc (Hons) Podiatry

We Did It!

On 11th November 2020, we The SMAE Institute, had the HCPC approval visit for our proposed BSc (Hons) Podiatry course to be delivered collaboratively with Queen Margaret University, Edinburgh. The event was very thorough and we are thrilled to announce the programme was recommended for approval by the HCPC, subject to some conditions being met.

There is now a period of a few months where the paperwork to meet these conditions needs to be processed, and once this has been achieved and the approval is confirmed in writing we will issue an updated statement to this effect. We remain on track for this programme to be operational by September 2021 and more information about the programme will be released in the next few months.

We wish to give special thanks to the programme team at SMAE and the wider team at QMU for all their hard work over many months and years to bring this to fruition.

We have been inundated with congratulatory messages which has truly bowled us over. Thank you to everyone who took the time to congratulate us.

This truly is a momentous day for the organisation and a positive day for the profession as a whole.

"Fabulous news and great to see all your hard work result in a very positive outcome for the profession! Be very proud!"
J.C

Excellent news, well done to you guys
L.P

Fantastic news! I can't wait. Congratulations
H.W

"Congratulations to all involved."
D.W

"That is incredible news. What a testament to you all as a team and your commitment to growth and expansion in education for all of us. A huge congratulations to each and everyone of you. "
M.C

"This is a great achievement and a positive step forwards for the podiatry profession and all foot health. Congrats "
B.L

"What an amazing achievement. Well done."
M.J

Queen Margaret University
EDINBURGH
Collaborative Partner


"I know you work so hard to make this happen and others too. Such an achievement. Congratulations to all who had input."
C.B
"This is fantastic news!!! I would be really interested in looking at this when I have passed my Foot Health course. Well done. "
C.G
"That's made my day..."
M.M
"Well done – a lot of hard work I'm sure."
N.S
"Brilliant! Congratulations to all who worked so hard to get to this point. Wishing you every success."
S.D
Congratulations!! So pleased for The SMAE Institute. Proud to be a member since 1994
S.L
"Congratulations... well done to everyone on the SMAE team to make this possible."
T.F
"Amazing news! Would LOVE to do this course!!!! "
L.M
"Amazing news congratulations on all the hard work that has clearly gone in to result in this momentous day ... WELL DONE!!!!"
A.H
"Super news. Well done to you, the team & QMU on getting this over the line."
E.O
"Many congratulations! And thank you."
S.M
"I so can't wait for this."
H.T
"It's long awaited and fantastic news. Congratulations to the Smae and all the team who have worked so hard to achieve this step... I remember discussing this at a conference years ago with some of the Smae lecturer's and the hope was a dim light back then. To finally reach this result is a testament to the dedication and commitment that the Smae have to their practitioner's and the future in foot health... well done..."
B.S

Christmas Closure Dates

The SMAE Institute

The SMAE Institute will be closed for the Christmas period at 12.00pm on Wednesday 23rd December and will reopen for business as usual on Monday 4th January 2021.

During this period the answer phone will be on for messages to action when SMAE reopens. Information is available on the website (www.smaeinstitute.co.uk).

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Podiacare Orders

Last orders for Podiacare should be placed on 18th December 2020 for despatch on 21st December 2020.

Podiacare will resume business at 9.00am on Monday 4th January 2021.

During this period, orders may be placed online, by fax, post or left on the answer phone, for processing when Podiacare reopens.

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Wishing everyone a very Merry Christmas and a Happy New Year

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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.

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COVID-19 UPDATE

In our earlier correspondence we indicated that, based upon clinical judgement, routine clinical practice could be resumed as usual. This advice remains in place and it is appropriate that you can be seeing the vast majority of patients within your caseload. It is crucial that above all else this is done carefully so as to protect your own health and well-being, and the health and well-being of the other members of your household. Please note that the most recent shift into regional tiers as directed by the Government DOES NOT impact your ability to provide treatment to patients as health care practices are allowed to continue within the guidelines. To that effect the main guidance that we provided you via our last update remains in place:

- ***If you or anyone in your household is displaying COVID-19 symptoms (fever and a new continuous cough) OR has had a case of COVID-19 confirmed, there is to be no service provided for a minimum of 14 days – and you will need to get a test for the virus***
- ***If your patient or anyone in their household is displaying COVID-19 symptoms (fever and a new continuous cough) OR has had a case of COVID-19 confirmed, there is to be no service provided for a minimum of 14 days – and you will need to enquire about whether they have booked a test / received a result***
- ***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 exercise careful clinical judgement before a decision is taken to provide treatment.***

As the spread of this virus appears to be increasing in the cooler months of the year, we all need to keep practicing cautiously so as to avoid unnecessary spreading of the disease.

Accordingly, you must still continue to make clinical judgements on whom to treat and when based upon these two considerations:

- ***How likely is it that failure to provide treatment to this patient will likely stretch precious NHS resource further and unnecessarily?***
- ***Is the risk to the patients' health and well-being of no treatment greater than the risk of them potentially contracting COVID-19?***

It remains an appropriate plan to tend to the needs of your most urgent and pressing cases first and gradually work towards those in less urgent need of foot care. These needs can, and should, be established via telephone consultation first where you can run through a series of screening questions related to their general health, potential infection / symptoms of Covid-19 and any foot problems that they may have.

If a local lockdown has affected you and your area you will need to abide by local authority rules and regulations. Our suggestion (if this affects you and your area at any point in time) would be as follows:

For domiciliary practice:

- ***Only provide foot care appointments in the event of an urgent / emergency foot problem, otherwise re-arrange until restrictions have eased again.***

For work in clinical premises:

- ***Please follow the advice in terms of premises that are permitted to carry out non-essential practice (i.e. non-essential shops; hairdressers etc). So, if restrictions are not reapplied to these then you can carry on as you are. If restrictions are applied then only provide foot care appointments in the event of an urgent / emergency foot problem - rearrange the non-urgent appointments.***

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:

- ***Make sure that all patients are pre-screened over the phone to ensure that attending to them is safe, required and possible (i.e. if their problem is likely to be out of your scope – please seek to arrange that remotely so that they minimise the amount of people they have to see to sort their problem out)***
- ***You may need to reduce the amount of patient caseloads that you see in a day – ensure that you have sufficient gaps between patient caseloads so as to allow for disposal of PPE items and decontamination of any accessory items that you would use patient-to-patient***
- ***You will need to seek to minimise the amount of time spent with patients WITHOUT reducing the quality of care that you provide. Prolonged exposure to individuals increases the risk of disease transmission. This might include completing the patient record card after you have left the company of your patient***
- ***Where possible, practical, appropriate and agreeable with the patient, seek to provide treatments in an outdoor environment or at least with good ventilation***
- ***Ensure that you employ the strictest infection control practices and have adequate PPE***
- ***Where possible seek to take payment over the phone or via card transaction***

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 where there is low suspicion of them having COVD-19. 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 and encouraged 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
- A ***face face shield / visor OR eye protection is recommended*** but not essential during the consultation (these can be wiped clean thoroughly with a disinfectant between patients)
- Regular aprons will suffice but you may wish to wear full-length sleeved gowns

Whilst it is not possible to fully socially distance whilst providing treatment to patients, we are fortunate that we are working at the distal end of their body and are typically >1m away from their face, mouth and nose. Thus, risk of transmission is relatively low compared to in other health and care profession contexts. Outside of the moments of treatment, you should seek to place a distance of >2m between you and the patient and you and anyone else in their households.

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

Understanding medication and pharmacotherapy:

Part 1 – Principles of drugs and drug therapy

By Andrew Hill
Clinical Service Manager & Programme Lead, The SMAE Institute

MSc Podiatry; BSc (Hons); PG Cert L&T; FFPM RCPS(Glasg); FHEA; FSSCh

IT IS CRUCIAL TO DEVELOP A STRONG WORKING KNOWLEDGE OF PHARMACOTHERAPY IN THE INTERESTS OF PATIENT SAFETY AND WELL-BEING

Medical pharmacology is the study of chemicals (drugs) that interact with the human body. It is a core aspect of medical interventions and all health professionals should take account of the medications that patients are taking. This can be a daunting and challenging area to understand well but it is crucial to develop a strong working knowledge of pharmacotherapy in the interests of patient safety and well-being. This series of articles will cover underpinning principles of drugs and drug therapy before moving into more granular discussion about common drug classes that we see in everyday practice. It is hoped this will help shape the understanding and practices of clinicians who are less well versed in the pharmacological aspects of their patients care. This article focuses on part 1 of this subject – principles of drugs and drug therapy.

The interaction of drugs with the body are divided into two classes:

- Pharmacodynamics
- Pharmacokinetics

Neal (2017) outlines that the pharmacodynamics of a drug are best thought of as the effects that the drug has on the body whilst the pharmacokinetics of a drug refers to the effect that the body has on the drug (i.e. absorption, distribution, metabolism and excretion). Figure 1 (below) illustrates this.

Pharmacodynamics

The most common ways in which a drug can produce its effects include:

- Non-specific drug action – acting by virtue of their physicochemical properties
- Acting as false substrates or inhibitors for certain transport systems or enzymes
- Acting on specific protein molecules

The last of those three, whereby drugs act on specific protein molecules, is the most common way in which a drug can produce its effects. The specific protein molecules that drugs act on are usually located in the cell membrane and are called receptors. These receptors usually respond to chemicals naturally produced by the body (either transmitter substances or hormones). Ergo, drugs often work by replicating the actions of naturally occurring chemicals in the body (Neal, 2017). Chemicals or drugs that activate receptors and produce a response are called agonists. Drugs which combine with receptors but do not activate them are called antagonists. Antagonists reduce the probability of the transmitter substance combining with the receptor and so in this way the antagonist acts as a blocking agent (Waller and Sampson, 2017).

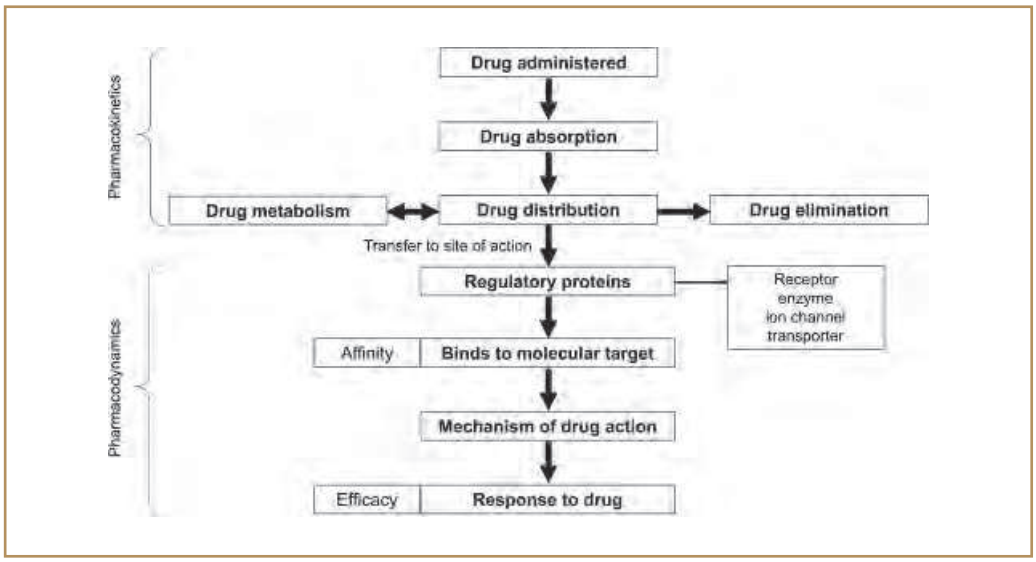

Figure 1. Pharmacodynamics vs Pharmacokinetics.

The activation receptors by an agonist (or hormone) is coupled to the physiological or biochemical responses by transduction mechanisms that often (but not always) involves molecules called second messengers (Neal, 2017). If the drug and the binding site at a receptor have a very close 'fit', it will produce a stronger bond between them and the higher the affinity between the drug and the receptor will be. The ability for a drug to bind with one particular type of receptor is called the specificity of the drug. Whilst no drug is truly specific, many are relatively selective and will often only work on one type of receptor (Whalen, 2018). These are important aspects to understand because as drugs produce specific chemical reactions in the body they are used for therapeutic effect but are very well known to produce additional unwanted effects (side effects) that range from the trivial (slight nausea) to the fatal.

Receptors

Receptors are protein molecules that are normally activated by transmitters or hormones. The four main types of receptor are listed below:

1. Agonist (ligand)-gate ion channels
2. G-protein-coupled receptors
3. Enzyme-linked receptors
4. Intracellular receptors

See figure 2.

Transport Systems

The lipid cell membrane provides a barrier against the transport of hydrophilic molecules in or out of the cell (Neal, 2017). Ion channels are selective pores that in the membrane that allow the ready transfer of ions down their electrochemical gradient. What controls whether these 'gates' are open or closed is either via the membrane potential (voltage-gated channels) or via transmitter substances (ligand-gated channels). Some ion channels are both (i.e. the calcium channels in the heart). Common examples of drugs that work on voltage-gated channels include calcium channel blockers and local anaesthetics (Whalen, 2018).

Active transport processes are used to transfer substances against their concentration gradients. They utilise special carrier molecules in the membrane and require metabolic energy to carry out their work. Examples of these include sodium pumps and norepinephrine transport (Waller and Sampson, 2017).

Agonists

Second messengers are chemicals whose intracellular concentration increases or (more rarely) decreases in response to receptor activation by an agonist (Neal, 2017). These secondary messengers trigger processes that eventually result in a cellular response. Illustrative examples of this is demonstrated in figure 3.

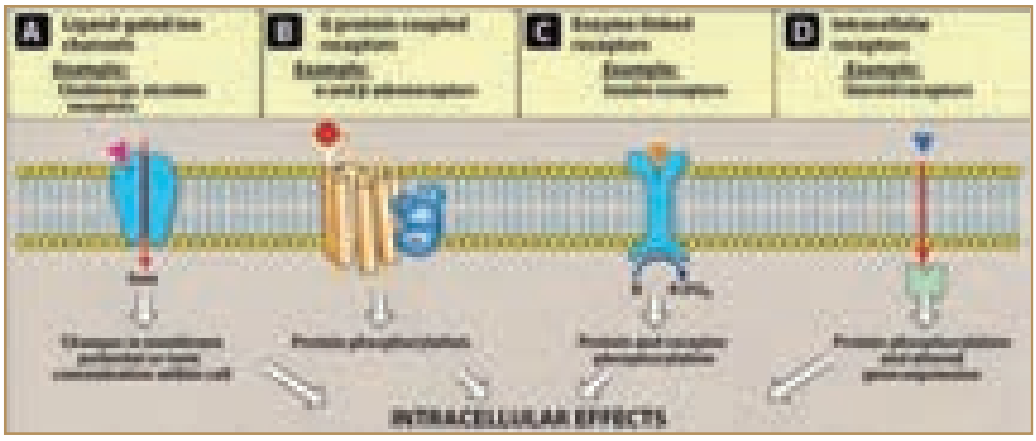

Figure 2. Receptor types

Notes:

Understanding medication and pharmacotherapy

The tissues in the body have only a few basic responses when exposed to agonists (e.g. muscle contraction, glandular secretion etc). Different effects can be produced, however, by the use of antagonists. Figure 4 outlines the differences between agonists and antagonists.

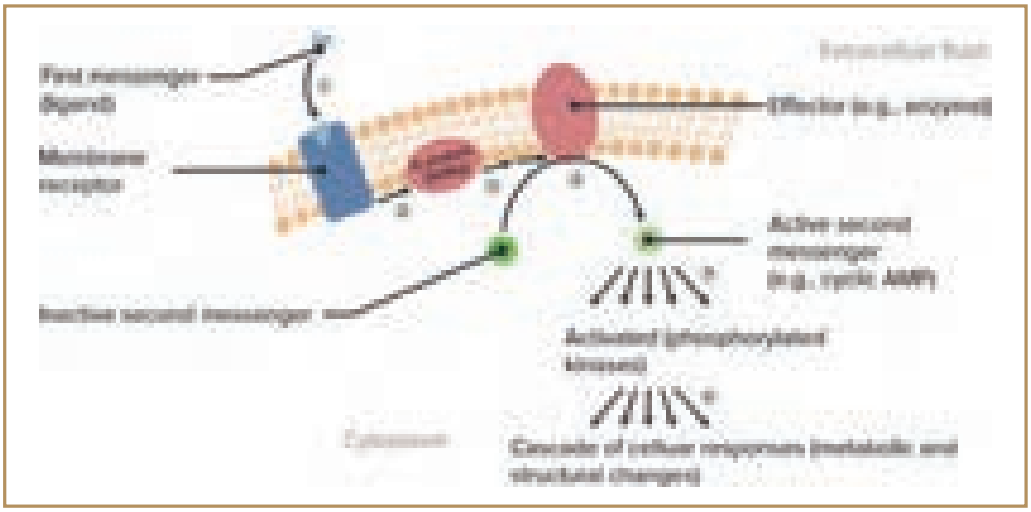

Figure 3. Second Messenger system response to activation by an agonist

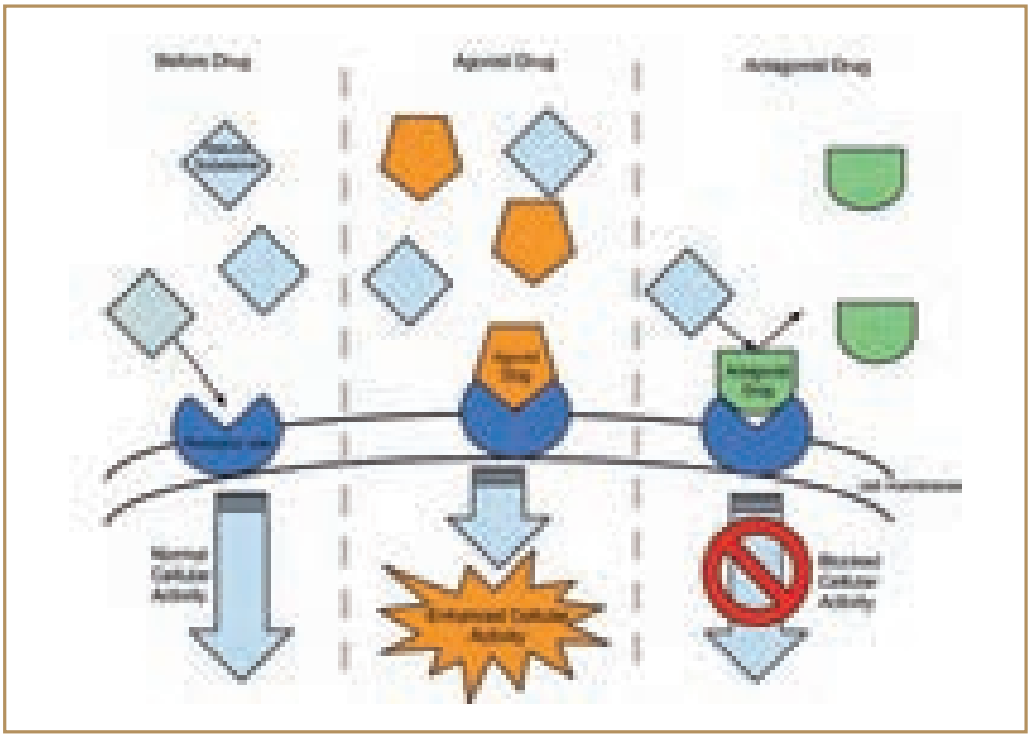

Figure 4. Agonist vs Antagonist

Antagonists

Most antagonists are drugs that bind to receptors but do not activate them. They may be competitive or irreversible. Other types are less common.

- Competitive antagonists bind reversibly with receptors. Tissue response can be returned to normal by increasing the dose of the agonist.
- Irreversible antagonists have an effect that cannot be reversed by increasing the concentration of the agonist
- Non-competitive antagonists do not bind to the receptor site but act downstream to prevent the response to an agonist
- Chemical antagonists simply bind to the active drug and inactivate it
- Physiological antagonists are two agents with opposite effects that tend to cancel one another out

Partial Agonists

Partial agonists are those that cannot elicit the same maximum response as a 'full' agonist and the reasons for this are unknown. When acting alone at receptors, partial agonists stimulate a physiological response, but they can antagonise the effects of a full agonist because some of the receptors previously occupied by the full agonist become occupied by the partial agonist which has a smaller effect (Neal, 2017; Whalen, 2018).

Tachyphylaxis, desensitisation, tolerance and drug resistance

When a drug is given repeatedly, its effects often reduce over time. In the reduction in effect occurs quickly (within minutes or hours), this is referred to as Tachyphylaxis or desensitisation. If this reduction in effect happens over a longer time frame (days or weeks) this is referred to as tolerance. Drug resistance is a term that is given to chemotherapeutic agents (i.e. antimalarials / antibiotics) (Waller and Sampson, 2017). Tolerance of a drug often involves increased metabolism or a decrease in receptor number whilst desensitisation often results from changes to the receptors themselves.

Pharmacokinetics

Routes of administration

Drugs can be administered orally or parenterally (i.e. not via the gastro-intestinal route). Figure 5 outlines the full range of possible drug administration routes. The main ones are presented below:

- Oral – most drugs are absorbed via this route and, largely owing to convenience, it is the most widely used. However, some drugs are destroyed by stomach acid or gut enzymes and so need to be given by alternative routes
- Intravenous injection – The drug directly enters into the circulation and bypasses the absorption barriers. This route is used:
  - Where rapid effect is required
  - For continuous administration (infusion)
  - For large volumes of drugs
  - For drugs that cause local tissue damage if given by other routes
- Intramuscular and subcutaneous injections – drugs in aqueous solution are usually absorbed fairly rapidly
- Other routes – (inhalation, sublingual, rectal, intrathecal)

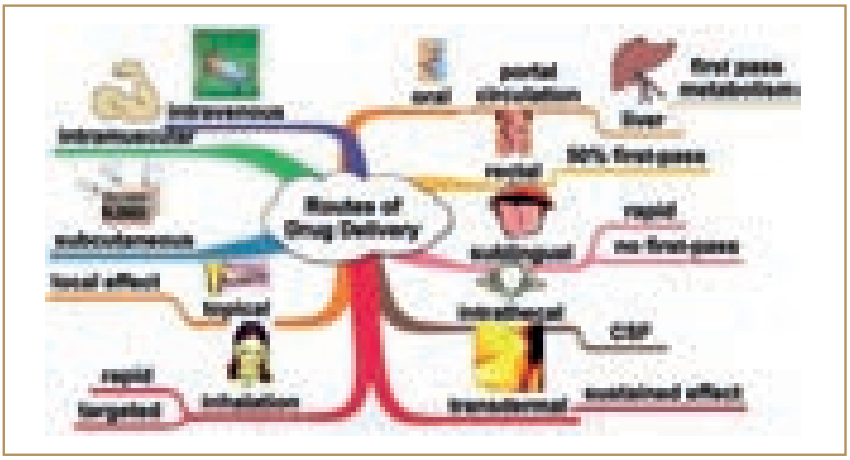

Figure 5. Routes of drug administration.

Understanding medication and pharmacotherapy

THE MAIN ORGAN OF DRUG METABOLISM IS THE LIVER, THOUGH OTHER ORGANS SUCH AS THE GASTROINTESTINAL TRACT AND LUNGS ALSO HAVE CONSIDERABLE METABOLIC ACTIVITY TOO

Distribution

Whalen (2018) points out that distribution around the body occurs when the drug reaches the circulation. It must then penetrate tissues to act. The half-life is the time taken for the concentration of the drug in the blood to fall by half its original value. Measurement of the half-life allows the calculation of the elimination rate constant to be determined which, in turn, enables calculations to be made as to how long it will take the body to eliminate the dose from the bloodstream (Waller and Sampson, 2017).

Key concepts in this aspect of the pharmacokinetics include the volume distribution (the apparent volume into which the drug is distributed); the clearance (the volume of blood or plasma cleared of the drug per unit of time); drug dosage (these are the dosage regimens that are based off of clearance values) and bioavailability (the terms used to describe the proportion of administered drug reaching the systemic circulation).

Excretion

Renal excretion is ultimately responsible for the elimination of most drugs though some go via biliary excretion. Biliary excretion is where some drugs are concentrated in the bile and excreted into the intestine where they may be reabsorbed. This enterohepatic circulation typically increases the persistence of a drug in the body (Neal, 2017).

Metabolism

A few drugs are highly polar because they are fully ionised at physiological pH. Such drugs are metabolised little, if at all, and their effects are only ended by renal excretion (Neal, 2017). However, most drugs do undergo metabolism as they are highly lipophilic and are often bound to plasma proteins (Whalen, 2018). This, intriguingly, makes renal excretion in the absence of metabolism much less possible. Therefore, generally speaking, drugs are typically metabolised into more polar compounds and are, thus, more easily excreted by the kidneys.

The main organ of drug metabolism is the liver, though other organs such as the gastrointestinal tract and lungs also have considerable metabolic activity too. Drugs given orally are usually absorbed in the small intestine and enter the portal system to travel to the liver, where they may be more extensively metabolised. This exact process is called first pass metabolism and is not exclusive to hepatic metabolism (Neal, 2017).

Phase I reactions

The most common phase I metabolic reaction is oxidation. Others, though less common, include reduction and hydrolysis. Cytochrome P450 enzymes form a superfamily of related enzymes that differ in aminoacid sequence. Neal (2017) points out that each of these is referred to as 'CYP' followed by the defining numbers and a letter. There are over 70 CYP gene families but only three are involved in hepatic drug metabolism (CYP1, CYP2 and CYP 3).

Phase II reactions

Phase II reactions typically occur in the liver and involve conjugation of a drug (or its phase I metabolite) with an endogenous substance. The resulting conjugates are typically less active and more polar and are, thus, more readily excreted by the kidneys (Waller and Sampson, 2017).

Factors affecting drug metabolism

There are some important factors to consider when looking at drug metabolism. Knowing what can affect this metabolism is an important part of understanding dosages, contra-indications and toxicity of drugs. Factors which affect drug metabolism include:

- Enzyme induction – the activity of some drugs may be significantly reduced by a second drug that increases the activity of drug-metabolising enzymes
- Enzyme inhibition – enzyme inhibition may cause adverse drug interactions. These interactions tend to occur more rapidly than those involving enzyme induction because they occur as soon as the inhibiting drug reaches a high enough concentration to compete with the affected drug.
- Genetic polymorphisms – Pharmacogenetics is the study of how genetic determinants affect drug action. In essence, the response to drugs may vary widely between individuals.
- Age – certain hepatic enzymes and renal mechanisms are reduced at birth relative to maturity – especially in preterm babies. Additionally, in the elderly hepatic metabolism of drugs may be reduced but declining renal function is usually more important.

Summary

It is hoped that this article has set the scene for understanding specific drug actions and side effects that will be discussed in the next paper in this series by first providing some underpinning framework in place by which to consider and understand the biological and chemical rules that underpin pharmacotherapy. Whilst these sections have provided a brief precis of the key concepts of pharmacokinetics and pharmacodynamics, a more detailed exploration of these can be found by sourcing and reviewing the books within the reference list for this article. The next part of this series will start focusing on specific drug classifications and outline the most commonly encountered drugs within these classifications and provide a brief overview of their mechanisms of action as well we key side effects and contraindications.

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3. Whalen, K., 2018. Lippincott illustrated reviews: pharmacology. Lippincott Williams & Wilkins.

Notes:

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- Third-party nominations are accepted.
- Nominations must be supported by client referees prepared to provide testimony if your nomination is shortlisted.

Let us decide who the winners are - don't count yourself out of the application process - YOU could be an award winner!

Please email the following details to Janet McKane at jmckane@smaeinstitute.co.uk

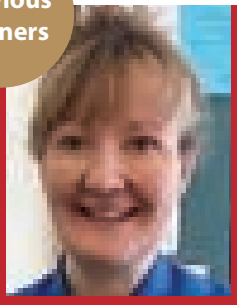
- Details of why you feel the nominee/nominees deserve to be rewarded
- Yours and the nominees name and address

Put your selected nominee forward for 'Practitioner of the Year 2020 Award'

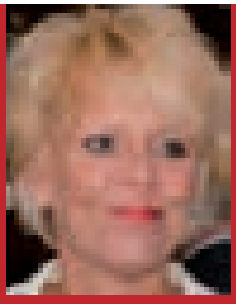
We want to reward those members who continue to develop themselves professionally, go the extra mile, and enjoy their role within the community. The winner of "Practitioner of the Year 2020" shall receive a place at one of our 2021 CPD Events (Summer School or Annual Conference) and a certificate, along with publicity on the SMAE Institute Website and in the 2021 Quarterly Journal. The runner up shall receive a CPD of their choice, from our Workshop or CPD@Home range.

The nomination process is straightforward and can be completed easily by an involved third party (a colleague, or client). The Winner will be announced in Spring 2021 Journal.

Previous Winners

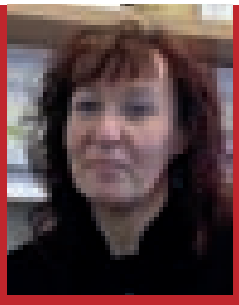


2016 Jenny Hyslop
BSc (Hons), DipPodMed, MSSCh MBChA



2017 Lesley Tanner
MCFHP MAFHP

2018 Ian Mitchell
MSSCh MBChA



2019 Trish Parker
MCFHP MAFHP

2020 WINNER
THIS COULD BE YOU!

Covid Toes; a possible cutaneous manifestation associated with SARS-Cov-2 coronavirus

By Belinda Longhurst
BSc (Hons), MCPod,
HCPC registered

Across the world, medical and health professionals are beginning to realise that there is an array of symptoms and signs associated with Covid-19; the disease caused by the current pandemic of the SARS-Cov-2 coronavirus. In addition to the recognised symptoms (fever, shortness of breath and anosmia) there are increasing reports of various dermatological conditions, including so called `Covid Toes` (de Masson *et al*, 2020). These lesions resemble perniosis (chilblains) and generally present on the hands and feet as erythematous, small, pruritic vesicles or pustules on younger patients who often have not manifested any other symptoms associated with Covid-19, but have usually had close contact with members in their household who have. These lesions appear to be related with less severe disease, are usually self-limiting and heal well without intervention (Razzaque, 2020). Curiously, tests on these patients for both antigen presence (current infection) and antibodies (previous infection) frequently reported as negative, suggesting the lesions are likely to be a delayed manifestation of the infection (Landa *et al*, 2020).

Foot Health Practitioners and podiatrists are familiar with patients presenting with true perniosis in the winter months, as exposure to cold causes constriction of the small arteries and veins in the skin. Subsequent rewarming of the skin too quickly results in leakage of blood into the tissues and swelling of the skin (perniosis). However, the pernio-like lesions that have been reported in Europe during the pandemic are unlikely to be related to cold exposure as they are manifesting during the summer season and may therefore, be associated with Covid-19 (Galván ***et al***, 2020). Thus, when patients present with these lesions, it is essential that a thorough medical, social and familial history is undertaken to ascertain risk of transmission.

THERE HAS BEEN A FLURRY OF EXPERT OPINION PAPERS PUBLISHED ON THE HYPOTHESISED ASSOCIATION OF ACRAL ERYTHEMATOUS LESIONS AND COVID-19

There has been a flurry of expert opinion papers published on the hypothesised association of acral erythematous lesions and Covid-19. The majority consist of small sample case studies which have not been subjected to the rigorous process of peer-review, and rightly so as the information should be made available to be of clinical use during the pandemic. There is sparse histological evidence on the pernio-like lesions, so aetiology remains unclear, however the scientific consensus from this growing body of work is that their manifestation is not coincidental.

One plausible proposition put forward by Lipsker (2020) is that some individuals may have an innate natural resistance to Covid-19 that clears the virus without achieving a secondary adaptive immune response. Hence, they do not produce identifiable antibodies. Since perniosis can be a clinical sign of an inherited innate autoimmune disorder - where there is an increased expression of the defence mechanism type I interferon (IFN-1) - the hypothesis is that infection of the virus triggers a strong release of IFN-1 to tackle the virus and results in the cutaneous lesions. Moreover, this could indicate that those naturally protected individuals will not only fail to develop antibodies, they would also prove negative for antigen presence.

Many viral infections produce skin changes such as petechiae, purpura and pox-like lesions. However, the current advice from the British Dermatological Association (BAD) is that self-isolation is not recommended for patients presenting with pernio-like lesions in the absence of the recognised Covid-19 symptoms of fever, shortness of breath and anosmia, unless others in the same household are symptomatic. The BAD have also advised, *"Members of the public should be very cautious about trying to self-diagnose COVID-19 based on skin symptoms; rashes and other skin lesions are common and hard to differentiate between without expertise".*

BAD are collecting information from Health Professionals on patients with confirmed or suspected Covid-19, who have also displayed new-onset skin symptoms. Once the data has been analysed, the correlation can then be determined to provide a greater insight into the pathogenesis of skin manifestations associated with Covid-19. To contribute your clinical experiences please complete the survey at **https://www.surveymonkey.co.uk/r/C-19-Dermatology**

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1. British Association of Dermatologists. Apr 30th, 2020 Press release: Five common skin manifestations of COVID-19 identified. Available at: https://www.bad.org.uk/media/news#]
2. Galván Casas C, Català A, Carretero Hernández G, et al. (2020) Classification of the cutaneous manifestations of COVID19: a rapid prospective nationwide consensus study in Spain with 375 cases. British Journal of Dermatology. Available at: https://doi.org/10.1111/bjd.19163. [Epub ahead of print].
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Diploma in Local Anaesthesia

www.smae-la.co.uk

The timetable for the 2021 Diploma is as follows:

Open / Registration Day (Location: The SMAE Institute)
Saturday 27th March 2021
This is a pre-requisite for those who wish to enrol

Introductory Lectures (Location: The SMAE Institute)
Friday 21st May 2021

Module 1 (Location: e-Learning)
Begins: Monday 24th May 2021

Module 1 Assessment Submission
Friday 20th August 2021

Module 2 (Location: e-Learning)
Begins: Monday 27th September 2021

Module 2 Assessment Submission
Friday 10th December 2021

Clinical Practice
Early 2022

The **Open Day for the 2021 Cohort** will be held on Saturday 27th March 2021. If you are interested and would like to attend 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.

*** Installment Option Available**

Diploma in Prescription Only Medicines

www.smae-poms.co.uk

Our next cohort begins December 2020. More information about the 2020 cohort can be found at www.smae-poms.co.uk

Open / Registration Day (Location: The SMAE Institute)
Saturday 7th November 2020
This was a pre-requisite for those who wish to enrol

Introductory Lectures (Location: The SMAE Institute)
Friday 27th November 2020

Module 1 (Location: e-Learning)
Begins: Monday 30th November 2020

Module 1 Assessment Submission
Monday 5th April 2021

Examination (Location: The SMAE Institute)
TBC (2021)

If you are interested in the 2021 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.

*** Installment Option Available**

hcpc health & care professions council

Top tips for completing a CPD audit following COVID-19

Natalie Berrie, Registration Manager, HCPC

Introduction

The safety and wellbeing of service users and patients has always been the top priority of the HCPC. One of the ways in which we ensure this is through requiring all of our registrants to undergo Continuing Professional Development (CPD) which we regularly audit.

At the start of the COVID-19 pandemic, registrants were facing increasing demands on their work and, as a regulator, we needed to be flexible to enable them to continue to deliver a high standard of care to patients and service users. We took the decision to suspend CPD audits, to enable health and care professionals to focus on their work in an unprecedented time of need. We also did all we could to boost the UK's health and care services, including the creation of emergency registers for students and returning professionals.

We hope that many of the professionals we regulate will have gained valuable insights from this extraordinary time in our country's public health. Many of our registrants have taken on new roles, undergone training for the use of PPE, and other COVID-19 specific procedures, and acquired new skills. We want to ensure that this learning is captured and give registrants time to reflect on how this pandemic has allowed them to develop. This is the reason why we are now resuming our CPD audits.

While there have been many positive learning experiences from this pandemic, we recognise that there has also been a real human impact, and that many of our registrants have faced challenging circumstances, negative impacts on mental health and increased demands at work. In September we responded to the Workforce Burnout consultation to share our registrants' experiences and, hopefully, shape government approaches to these situations in the future. We also recognise that there is a strong possibility that workload, hospital admissions and lockdown measures may increase again.

Extra provisions

We have introduced some extra flexibility for this audit: if there is a gap of 3 or more consecutive months during the COVID period, registrants can explain that they were unable to do CPD due to the crisis.

If a registrant feels they need more time to submit their CPD profile they can request an extension. Just email cpdprofiles@hcpc-uk.org with the reason and how long is needed. Likewise, if you feel you need more support please send details to cpdprofiles@hcpc-uk.org.

More information about completing a CPD profile is in the CPD section.

COVID-specific tips

The content of your CPD activities will, inevitably, have seen some significant changes during the past few months, so we have compiled a few tips on completing CPD profiles following COVID-19.

Your CPD profile should be a record of the significant experiences and learning opportunities you have used to develop as a professional during the past two years. The profile should include a record of different types of CPD activities relevant to your current or future practice as well as a statement explaining how several CPD activities from the record have contributed to the quality of your practice and benefited service users, with evidence to support it.

1. **Reflect on your self-directed learning through the pandemic**
   All health and care professionals will have undertaken a significant amount of self-directed learning throughout the pandemic. These periods of time will certainly have affected your professional development. The sources of this information, your response to it and how it will affect your future work are relevant things to record.
2. **Reflect on training through the pandemic**
   Most health and care professionals will have needed to undertake specific training to cope with COVID-19, whether that was in patient care or around using PPE. Reflection on this learning, as well as how it may affect your future work, will be relevant to record.
3. **Don't record all work activities**
   Work activities are only relevant to CPD if there is significance to them – for example something unforeseen in a case that gave you reason to respond differently, learn or reflect. The majority of your day-to-day work activities will utilise your learning, rather than adding to it. There is no need to record these.
4. **Don't struggle to fill the COVID gap**
   If there is a gap of three or more consecutive months due to the COVID-19 period, you can explain the gap is due to COVID-19 and provide details.
5. **Don't limit yourself**
   Some CPD activities are obvious, such as work-based learning, formal courses, talks and presentations or mentoring. However, there are many others besides these. Any occasion on which you had cause to reflect and develop accordingly will count as CPD - whether that is a discussion about a case with colleagues or reading relevant articles in a journal. If you can demonstrate how the activity meets the Standards of CPD, it can be part of your profile.
6. **Show how your CPD meets the standards clearly**
   It's the quality of your CPD, rather than the quantity, which matters when submitting a profile. The number and frequency of your activities will vary depending on your current or future practice, so focusing on demonstrating how your they have benefited your unique practice will help your profile meet the standards of CPD.

Registrants selected for audit will hear from us via post and email shortly after the selection. Information on completing and submitting your profile will be provided with this communication.

For more information on CPD visit our website. You can also visit our COVID-19 hub for more specific guidance and information during the pandemic.

A Review of

Circulatory Disorders of the Foot in Diabetes and Ligament Injury

By Dr. T. Javed
MBChA, FSSCh

ABSTRACT

In this article, the implications of vascular disease in the lower limb of patients with diabetes and its clinical features are discussed with regards to various factors that influence the disease. Common arterial lesions which are characterized by local intimal thickenings of smooth muscle cells, macrophages, lipids derived from peri- and intracellular serum lipoprotein deposits, and connective tissue viz: mucopolysaccharides, collagen and elastin are involved.

1. INTRODUCTION

Diabetes mellitus is defined as an absolute or relative insulin deficiency (insulinopenia) with consequential hyperglycemia. Atherosclerotic cardiovascular disease[1] is a common complication of diabetes[2,3]. Some of the common risk factors for diabetes mellitus and atherosclerosis include: dislipoproteinemia, obesity, hypertension, psychological disturbance, and lack of exercise. Diabetic patients have a two to four-fold risk of coronary artery disease[4]. In these individuals, the risk of developing of carotid artery atherosclerosis have been reported to increase with hypercholesterolemia[5,6].

This is associated with elevated levels of low density lipoproteins (LDLs) and low levels of high density lipoproteins (HDLs). Similar findings have been found for hypertriglyceridemia[7,8].

Diabetes mellitus is a marked risk factor in the onset of atherosclerosis particularly in the early stages. On the other hand, atherosclerosis is a significant additional factor of exacerbation of late stage diabetes leading to complications with potential for alterations. Long-term hyperglycemia can also lead to complications of diabetes mellitus by alteration of small and large blood vessels of the circulatory system, nerves, and basal membrane of various tissues[9].

2. DISCUSSION

A gradual decrease in insulin concentration to minimal values which inhibit lipolysis and ketogenesis but with marked compromise to the cellular glucose intake, leads to pronounced hyperglycemia with abundant osmotic diuresis and dehydration, with development of hyperosmolar state and coma.

Hyperglycemia, osmotic diuresis, loss of fluid and electrolytes, dehydration, ketonemia and metabolic acidosis are all common features of diabetic ketoacidosis which may exacerbate to coma. In severe hyperosmolar and ketoacidotic states, diminished tissue perfusion increases the concentration of lactic acid as a result of the metabolic effect of anaerobic tissue. Deficiency of oxygen stops the Krebs cycle and with formation of lactates from pyruvates resulting in lactacidosis. The metabolic pathway for the degradation of protein, carbohydrate, fat and fatty acids which is typical of type II diabetes mellitus is shown in Fig. 1.

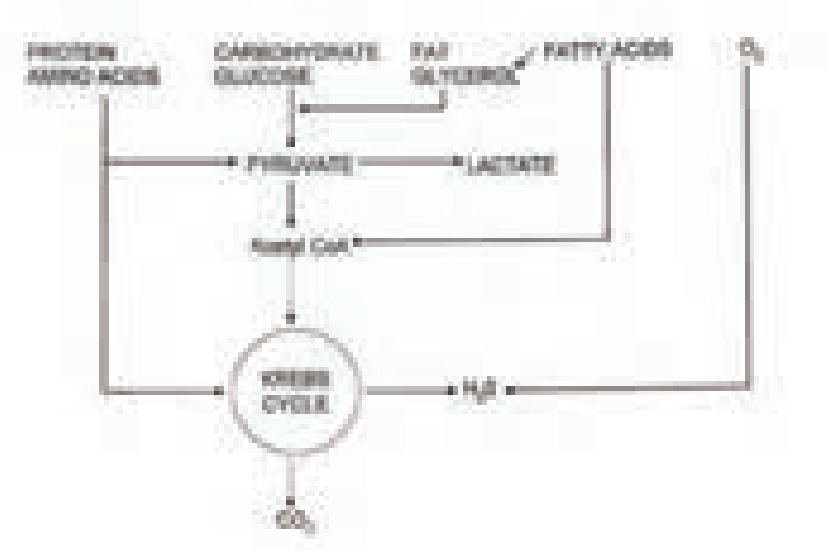

Figure 1. Metabolic Pathway for the Degradation of Protein, Carbohydrate, Fat and Fatty Acids

2.1 CLINICAL FEATURES OF ANGIOPATHY IN DIABETICS

2.1.1. Signs and Symptoms of Vascular Disease in The Lower Limb of Patients with Diabetes

- Intermittent Claudication
- Nocturnal Pain
- Rest Pain
- Noctural
- Nocturnal and Rest Pain Relieved by Dependency
- Cold Feet
- Absent/Poor Pulses
- Ischaemic Index/Ankle Brachial Blood Pressure
- Blanching on Elevation
- Dependency Rubor
- Delayed Venous Refilling After Elevation
- Atrophy of Subcutaneous Fatty Tissue
- Atrophy of Skin
- Loss of Hair Growth
- Deformity of Nails
- Ischaemic Ulceration
- Gangrene
- Amputation

2.3. ATHEROSCLEROSIS AND DIABETES

Atherosclerosis and diabetes is associated with:

- Age – onset at least 10 years earlier
- Sex – in non-diabetics the condition is more prevalent in males up to the age of 50; thereafter men and women are equal due to the menopause. Women lose their protection and the condition is said to be equal throughout.

A cross-section diagram of a blood vessel showing the effects of atherosclerosis and diabetes with a typical microscopic view of the blood vessels are shown in Fig. 2.

2.4. VASCULAR MICROTHROMBOSIS

Vascular microthrombosis is one of the basic atherosclerotic effects of cigarette smoking. Smoking has been postulated to decrease the level of HDL cholesterol, which has a similar effect. The problem of decreased oxygen transport in diabetic patients is further compromised by cigarette smoking, and this contributes to the development of late diabetes complications. Attempts to quit smoking should be made even at an older age, since it has been reported that those aged 60 years have a life expectancy of more than 20 Years.

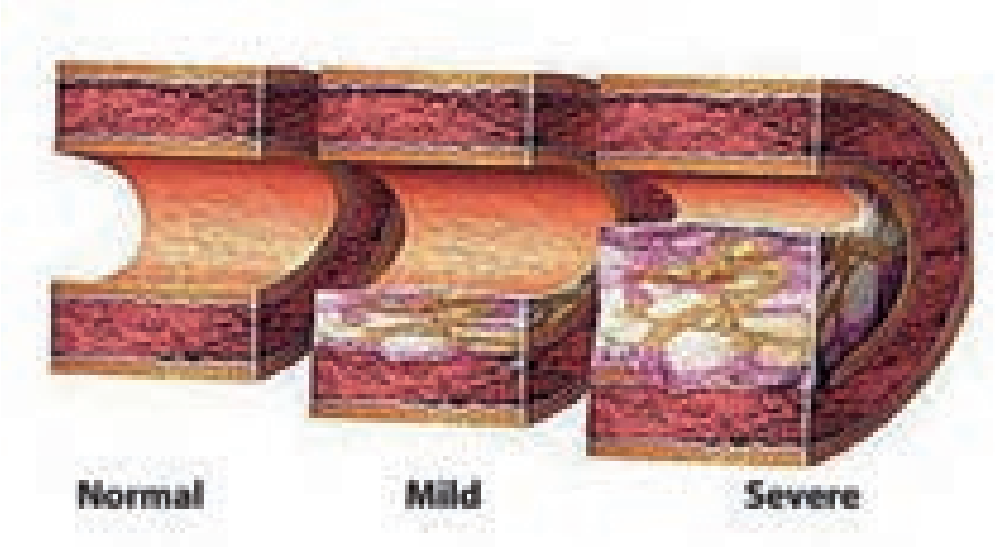

Figure 2. Cross-Section of a Blood Vessels: Illustration of The Effect of Atherosclerosis and Diabetes

Notes:

A Review of Circulatory Disorders of the Foot in Diabetes and Ligament Injury

THE PATTERN OF FAT METABOLISM IS GENERALLY SIMILAR IN A TYPE I DIABETIC PATIENT AND A NON-DIABETIC INDIVIDUAL

Fat metabolism disturbances occur more commonly in patients with type II diabetes. Small, dense LDL particles, are normally associated with the risk of vascular changes[10-13], predominately in type II diabetes mellitus. Patients with this type of diabetes mellitus have pronounced postprandial chylomicronemia even if the fasting triglycerides are found to be normal. Dyslipoproteinemia in type II diabetes mellitus is closely related with insulin resistance and hyperinsulinemia. This part of the insulin resistance syndrome is also sometimes called the metabolic syndrome. Contributing conditions and factors include hypertension, abdominal obesity, impairment of fat metabolism, accelerated atherosclerosis and impaired of glucose tolerance.

2.5. PRECIPITATING FACTORS ASSOCIATED WITH ATHEROSCLEROSIS

A large number of precipitating factors are associated with the development of atherosclerosis. Some of these include:

- Cigarette smoking
- Hypertension
- Diabetes Mellitus
- Obesity: Abdominal obesity is known to be caused by complex regulatory mechanisms of extrinsic (sympathetic-parasympathetic and endocrine) and intrinsic (enteric nervous system and paracrine secretion) factors which may be involved in the association of diabetes mellitus[14] and atherosclerosis
- Sedentary existence
- High serum cholesterol and triglycerides, and
- Stress

2.6. PRECIPITATING FACTORS

- **Site** – in diabetics the condition presents more distal in comparison to non diabetics i.e. popliteal and tibial compared to femoral and iliac
- **Presentation** – in diabetics the presentation of the condition is bilateral, whilst in non – diabetics the presentation is unilateral
- **Duration of diabetes** – it is thought that here there is a correlation i.e. The greater the duration of diabetes, the greater the risk of atherosclerosis

2.7. HYPERLIPIDAEMIA

- Cholesterol – normal value 6.0 – 7.5 mol/l.
- Carried in low density lipoproteins (LDL) 70% and high density lipoproteins (HDL) 30%
- Triglycerides – carried mainly in very low density lipoproteins (VLDL)

The risk of atherosclerosis can be minimised by:

- Maintaining the levels of LDLs (low) and HDLs (high)
- In general the higher the level of cholesterol in the blood, the more rapidly it is deposited in or on the arterial wall

2.8. DYSLIPOPROTEINEMIA

The pattern of fat metabolism is generally similar in a type I diabetic patient and a non-diabetic individual. However, in diabetic patients, the lack of insulin in the liver triggers greater formation of apoprotein B-containing lipoproteins. In poorly regulated diabetes mellitus, cholesterol, triglycerides, very low density lipoproteins (VLDL), and occasionally low density lipoproteins (LDL) are increased, and high density lipoproteins (HDLs) are decreased. In cases of acidosis, severe hyperlipoproteinemia with chylomicronemia develops. This condition is readily recovered by the action of insulin. In the elderly and those who are poorly regulated and/or are obese or have nephropathy are at a greater risk of hyperlipoproteinemia.

2.9. HYPERINSULINAEMIA

- Excess insulin in the blood
- Found in type 2 diabetes
- Obese diabetic patients (insulin resistant)
- High levels of insulin stimulate the incorporation of cholesterol and lipids into atheromatous plaques
- Insulin inhibits the action of hydrolysing lipase which removes fat

2.10. HYPERGLYCAEMIA

- Impairment of vessel wall nutrition
- Changes in coagulation effects has a direct stimulating effect on smooth muscle
- Disturbance in haemodynamics – increased viscosity leads to hypercoagulated state – increased platelet adhesion and aggregation; red blood cell deformation and aggregation and endothelial cells show functional disturbances

The effect of circulatory disturbance of macrovascular and microvascular complications of the feet is shown in Figures 3, 4, 5, 6 and 7.

Figure 3. Circulatory Disturbance of Macrovascular and Microvascular Complications: The Ankle

Figure 4. Circulatory Disturbance of Macrovascular and Microvascular Complications: The Great Toe

Figure 5. Circulatory Disturbance of Macrovascular and Microvascular Complications of the Foot: Superficial Aspect

Figure 6. Circulatory Disturbance of Macrovascular and Microvascular Complications of the Foot: Wet Gangrene

Figure 7. Circulatory Disturbance of Macrovascular and Microvascular Complications of the Foot: Plantar Aspect

2.11. MEDIAL CALCIFICATION / MONCKEBERG'S SCLEROSIS

- Accompanies the aging process and can assist the detrimental effect of atherosclerosis
- Occurs in the muscular arteries in the media
- Deposition of calcium salts in a) atheromatous plaques b) tunica media
- Increased incidence in diabetic patients.

2.12. PATHOLOGY OF ATHEROMA

- Begins with the development of small fatty streaks of lipid containing material on the arterial intima
- Intimal thickening with the formation of an atheromatous plaque which slowly increases in size

Notes:

A Review of Circulatory Disorders of the Foot in Diabetes and Ligament Injury

- The atheromatous plaque may ulcerate – atheromatous ulcer – secondary thrombosis
- Occasionally haemorrhage may occur into an atheromatous plaque
- Calcification of atheromatous ulcers may occur.

2.13. PODIATRIC IMPLICATIONS OF VASCULAR DISEASE IN A DIABETIC PATIENT

- Assess vascular supply at each visit
- Check medication at each visit
- Neuropathy – oedema. Avoid use of restrictive dressings
- Retinopathy – impaired vision
- If arterial supply is compromised use aseptic technique
- Avoid use of caustics
- Manufacture insoles to redistribute pressure

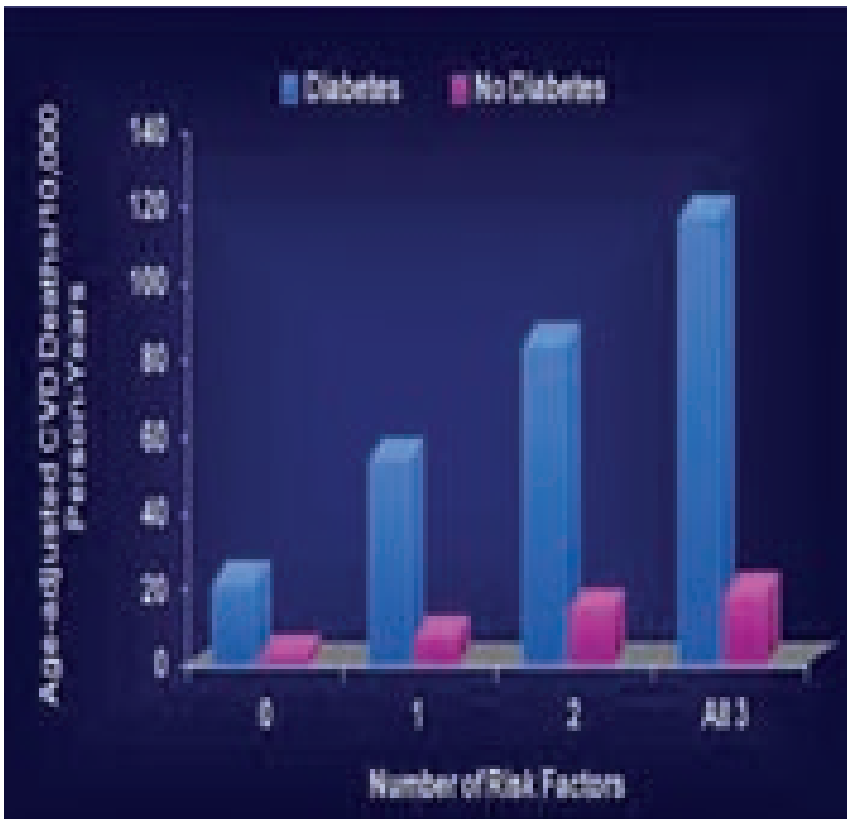

Figure 8. Age-Adjusted CVD versus Risk Factors

2.14. THE IMPACT OF MACROVASCULAR AND MICROVASCULAR DISEASE IN DIABETICS

Researchers reported that there is clear evidence which links psychological factors to coronary heart disease and hypertension, with consequential relationship to stress control. However, functional recovery after myocardial infarction is largely dependent on social support and stress control[15]. Several psychological factors have been known to contribute to risk factors. Stamler J et al[16] reported the relationship of age-adjusted CVD with the risk factors were involved (Fig. 8). Similarly, discontent in treated men with hypertension and marked cardiovascular risk has been shown to be significantly and independently associated with carotid artery intimal or medial thickening. Positive feelings[17] can also influence the process of atherosclerosis.

In a population size of approximately 5 million (Fig. 9) complications of diabetes suggests that to a variable degree the disease leads to a number of other conditions including: retinopathy (26%), nephropathy (5%), neuropathy (28%), peripheral vascular disease (11%), cardiovascular disease (17%) and cerebrovascular disease (6%).

2.15. MACROVASCULAR

- Long-term complications of diabetes mellitus can be classified into 3 major types: macrovascular disease, microvascular disease, and endocrine complications
- Macrovascular disease, which affects the large vessels of the body, such as the coronary or lower extremity arteries (e.g. femoral, popliteal), may result in myocardial infarction and peripheral vascular occlusive disease, respectively
- Up to 80% of deaths in people with type 2 diabetes are attributed to cardiovascular disease and stroke
- The increased prevalence of macrovascular disease in people with diabetes is due to many factors[18-21] including, but not limited to, obesity, lipid abnormalities, hypertension, hyperglycemia, hypercoagulation, platelet dysfunction, inflammation and endothelial dysfunction.

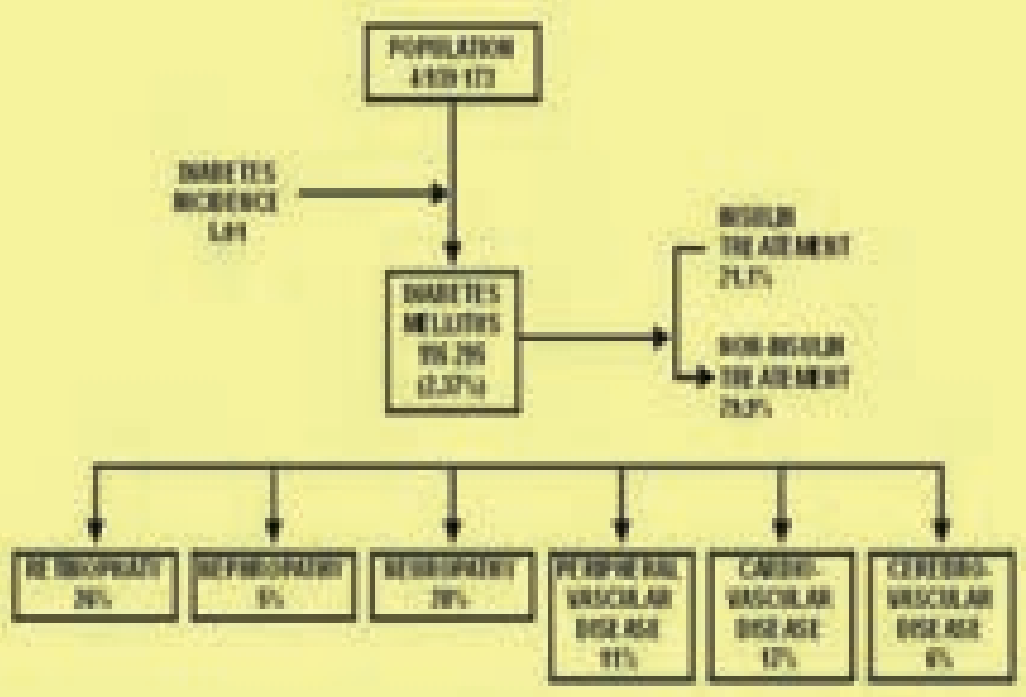

Figure 9. Approximate Incidence of Diabetes Complications in a Typical Population Size

2.16. MICROVASCULAR

Diabetic microvascular disease affects the small vessels, such as those supplying the retina, nerves, and kidneys. In particular:

- End organ damage can lead to diabetic retinopathy and blindness, diabetic neuropathy, which may result in lower limb amputation and diabetic nephropathy, often leading to end-stage renal disease requiring dialysis or transplantation
- It is well established that chronic hyperglycemia results in these primary chronic microvascular complications of diabetes
- Diabetes is the leading cause of renal failure and adult blindness in developed countries
- Theories on how hyperglycemia contributes to microvascular damage are emerging, with the hope of providing additional pharmacotherapeutic interventions[22-27] to prevent or slow the progression of chronic diabetes-related microvascular disease
- The prominent contemporary biochemical pathway theories on how diabetes causes damage to the microvasculature include, but are not limited to:

    1. Increased polyol (sorbitol/aldose reductase) pathway flux
    2. Production of advanced glycation end-products (AGE)
    3. Generation of reactive oxygen species, and
    4. Activation of diacylglycerol and protein kinase C isoforms.

Figure 10 shows the pattern of distribution of microvascular and macrovascular complications in the body. It can be observed that it affects the entire body resulting in viz: transient ischaemic attack, stroke, angina, myocardial infarction, cardiac failure, peripheral disease, diabetic neuropathy, macular oedema, microalbuminuria, renal disease, erectile dysfunction, autonomic neuropathy, peripheral neuropathy, osteomyelitis and amputation.

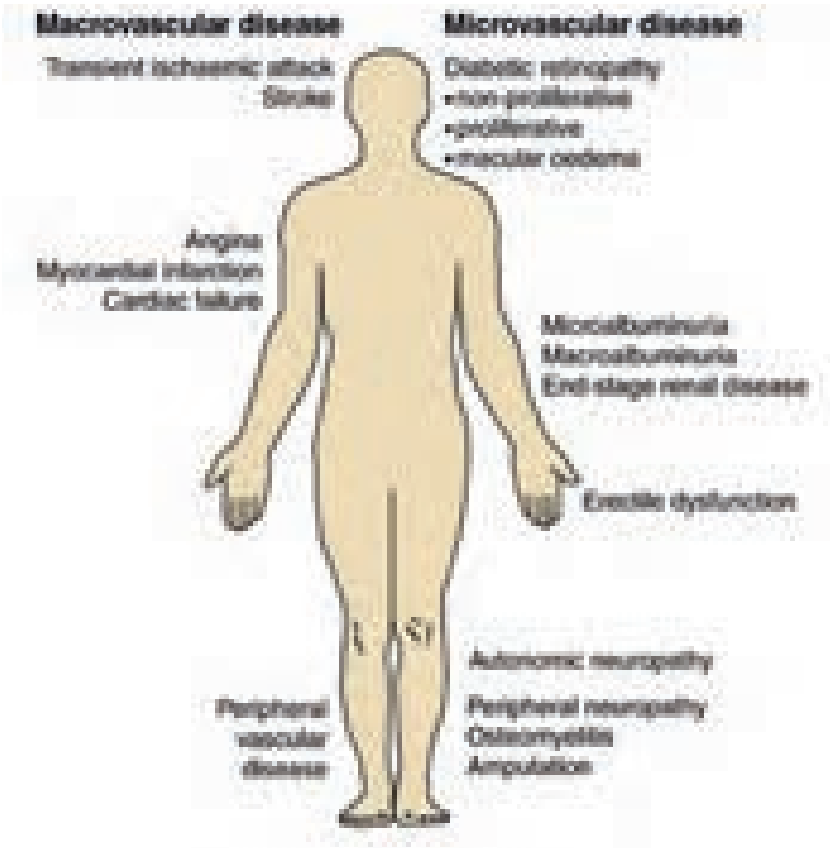

Figure 10. The Pattern of Distribution of Microvascular and Macrovascular Complications of the Body

A Review of Circulatory Disorders of the Foot in Diabetes and Ligament Injury

2.17. INCREASED POLYOL (SORBITOL/ALDOSE REDUCTASE) PATHWAY FLUX

1. Most cells in the body require the presence and action of insulin for glucose to gain entry into the intracellular compartment
2. However, vascular endothelial cells of the retina, kidney, and nervous tissue are insulin independent; therefore, there is a free interchange of glucose from the extracellular to intracellular environment regardless of insulin's presence or action.[28-34]
3. This diffusion of glucose into retinal, nerve, and kidney microvascular endothelial cells allows normal physiologic cellular functions to proceed during the euglycemic state, with any excess glucose being promptly metabolized to sorbitol by the enzyme aldose reductase.
4. Aldose reductase has a low affinity for glucose at normal glucose concentrations, and metabolism of glucose by the polyol pathway accounts for a very small percentage of glucose use under euglycemic conditions (i.e. maintenance of a constant blood glucose level by perfusion or infusion with glucose or insulin).
5. However, in the hyperglycemic state, excess glucose enters the polyol pathway, resulting in excess sorbitol production, with a concomitant decrease in nicotinamide-adenine dinucleotide phosphate (NADPH).
6. Cataracts are twice as common in patients with diabetes, although the exact mechanism involved in the development of the cataracts is unknown.
7. It appears that increased expression of aldose reductase occurs in the lens, with excess sorbitol formation and crystallization contributing to the development of cataracts.

It has been proposed that, when sorbitol is expressed in tissues, the utilization of oxygen is decreased, resulting in damage to the nerves, kidney cells and the eye.

2.18. RISK FACTORS FOR ATHEROSCLEROSIS

The reversible changes of atherosclerosis[34-40] are normally only treatable to a certain degree in the advancement of vascular intimal lesion. Modifications in the patient's behavioural pattern and the use of hypolipemic agents, are usually recommended. This stage, however usually proceeds unnoticed, and so treatment would only follow once the complications of atherosclerosis have been developed unless the condition can be intercepted by intervention in time.

2.19. LIGAMENT INJURY

Ligament - fibrous dense connective tissue - binds bones

- Injuries to these structures may be a precursor to osteoarthritis
- Has functional subunits that tighten or loosen depending on joint position
- Is not densely innervated or densely vascularized
    - Do contain some blood vessels and nerves in outer covering (epiligament)
    - Do contain proprioceptors
    - Do transmits pain signals via type c fibers
- In bone-ligament-bone structures, ligament is the weakest link
- Ligaments are not readily weakened by inactivity (takes many weeks)
- It is currently not known whether any modalities aid in ligament healing
- Surgical repair not done unless ends are significantly far apart - Length of repair scar does not affect final functionality or tensile strength

2.20. LIGAMENT SPRAIN

(i) Ligament sprain classifications

- Grade I - slight incomplete tear - no notable joint instability
- Grade II - moderate / severe incomplete tear - some joint instability
    - One ligament may be completely torn
- Grade III - complete tearing of 1 or more ligaments - obvious instability
    - Surgery usually required

(ii). In most cases, more than one ligament share loads around a joint - most sprains involve more than one ligament - example: ankle

- Most common sprain: ankle inversion accompanied by plantar flexion
- Primary ligaments: anterior talofibular and calcaneofibular ligaments
- If sprain is severe, "backup" structures may sometimes be involved
  Backup structures include: posterior talofibular ligament and peroneal tendons
- Most common knee sprain: valgus force to knee - medial collateral tear
  Backup structure include: anterior cruciate (cruciates blood supply inferior to collaterals)
- Joint instability in knee sprain likely to be evident only in injury position
- Repeat injuries not only tear healed areas but backup structures as well
- Prevention of re-injury is of critical importance

2.21. REPAIR SURGERY

The key steps involved in anterior cruciate ligament (ACL) repair surgery is illustrated in Figures 11 to13.

1. Suture anchor placed in condyle of femur in and through the site of normal ACL origin (Fig. 11).

Figure 11. Suture anchor placed in condyle of femur

2. Ends of ACL approximated using the sutures from the anchor (Fig. 12).

Figure 12. Approximating the ends of ACL

A clot of the patients own blood is formed and attached to the suture site (Fig. 13).

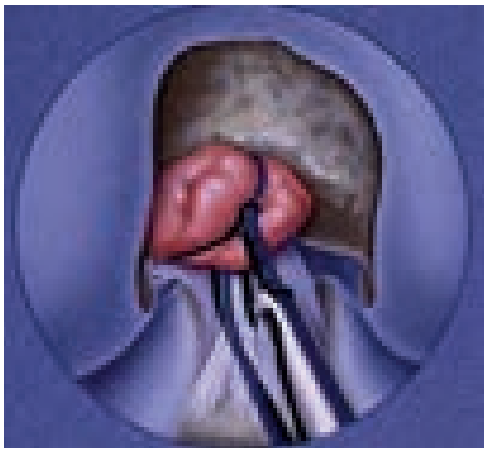

Figure 13. Clot of blood formed and attached to the suture site

IN MOST CASES, MORE THAN ONE LIGAMENT SHARE LOADS AROUND A JOINT - MOST SPRAINS INVOLVE MORE THAN ONE LIGAMENT

A Review of Circulatory Disorders of the Foot in Diabetes and Ligament Injury

2.22. RE-CONSTRUCTION SURGERY

The steps involved in the process of re-construction surgery are illustrated in Figures 14 and 15.

1. Harvest of "ligament replacement" from donor site (Patellar Tendon). Note: Hamstring tendons are becoming more preferable (Fig. 14).

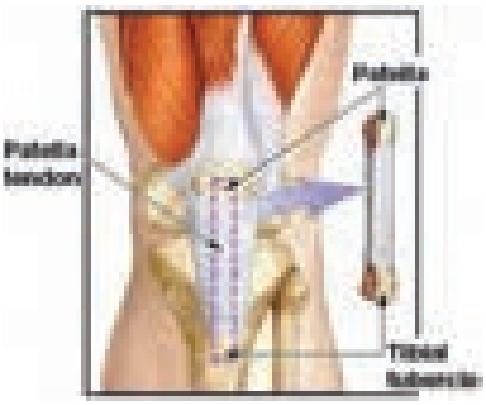

Figure 14. Ligament replacement from donor site (Patellar Tendon)

2. Grafting of replacement into holes drilled into the femur and tibia (Fig. 15)

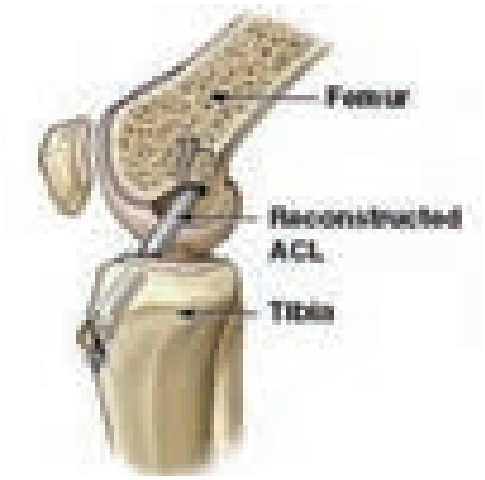

Figure 15. Grafting of replacement: Holes drilled into femur and tibia

2.23. TENDON RUPTURE

- Tendon - dense regular tissue attaching muscle to bone
  - Forces of 2000 psi have been recorded in the human Achilles (running)
  - Max tensile strength is 4 times maximum force production in muscle
- Tendon rupture - most often seen in Achilles
  - Age 30, blood flow in an area of 2-6 cm above calcaneal insertion
    Most tears occur here
  - Tendon can still function with as little as 25% of the fibres intact
  - Tears due to steroid injection abuse occur 2 - 4 weeks after last injection
- Complete tendon rupture diagnosed via the following symptoms
  - Palpable and sometimes observe a visible gap above calcaneous
  - Excessive passive dorsiflexion
  - Absence of plantar flexion when calf muscle squeezed (Thompson test)
- Tendon rupture treated with casting or surgery (usually both)

Surgery is best when tear is complete:-

1. Results in maximal restoration of both optimal length and tensile strength
2. After surgery foot is immobilized in plantar flexed position[41-50]
3. At 4 weeks, foot is brought to neutral position and re-casted
4. At 6 weeks, cast is removed and gentle weight bearing and exercise begins
5. Bounding type exercises begin no earlier than 12 weeks

- Casting alone is best in partial tears and in older non-competitive athletes

2.24. BONE FRACTURES

- Most fractures occur to the shaft of long bones[51-57]
- Bone is well vascularized and highly innervated
- Heals relatively rapidly when ends are well approximated (6 weeks or less)
- Healed bone often stronger than original due to external calcification

2.25. FRACTURE TYPES

Various types of fractures are briefly described in Table 1

Fracture Types	Description
Simple (closed)	Little or no bone displacement
Compound	Fracture ruptures the skin and bone protrudes
Green stick	Occurs mostly in children whose bones have not calcified or hardened
Transverse	Crack perpendicular to long axis of the bone - displacement may occur
Oblique	Diagonal crack across the long axis of the bone - u chance of displacement
Spiral	Diagonal crack involving a "twisting" of the bone about the longitudinal axis (occurs in skiing when bindings are too tight)
Comminuted (blowout)	"Crushing" fracture - more common in elderly - may require screws, rods, and wires - may cause permanent discrepancy in leg length
Impacted	One end of bone is driven up into the other - may result in length discrepancy
Depressed	Broken bone is pressed inward (skull fracture)
Avulsion	Fragment of bone is pulled away by tendon (Hip flexors, adductors)

Table1: Types of Fractures

CONCLUSION

- Long-term complications of diabetes mellitus are classified into 3 major types: macrovascular disease, microvascular disease and endocrine complications;
- Macrovascular disease, affects the large vessels of the body, such as the coronary or lower extremity arteries (e.g. femoral, popliteal). This may result in myocardial infarction and peripheral vascular occlusive disease, respectively;
- Diabetic microvascular disease affects the small vessels, such as those supplying the retina, nerves, and kidneys;
- End organ damage can lead to diabetic retinopathy, blindness and diabetic neuropathy. This may result in lower limb amputation, and diabetic nephropathy of chronic diabetes-related microvascular disease;
- The biochemical theories on how diabetes causes damage to the microvasculature include, but are not limited to:

1. Increased polyol (sorbitol/aldose reductase) pathway flux
2. Production of advanced glycation end-products (age)
3. Generation of reactive oxygen species, and
4. Activation of diacylglycerol and protein kinase c isoforms.

The purpose of this review and study is to objectively quantify the ligaments. Notably, there is a significant difference in the area, width and height, between all ligaments. The dorsal ligament is the smallest, with the least height, width, and cross-sectional area. The interosseous ligament is the largest, with the greatest height, width, and cross-sectional area. The plantar ligament is twice as large as the dorsal ligament. The interosseous ligament is the largest. In comparison, on average, it is 4.5 times larger than the dorsal ligament and twice as large as the plantar ligament.

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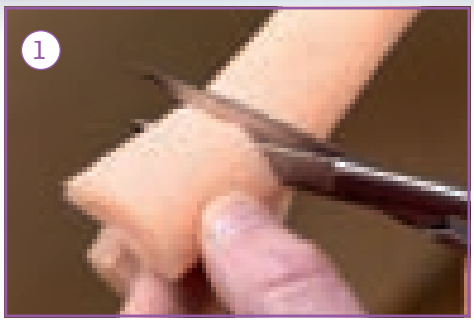


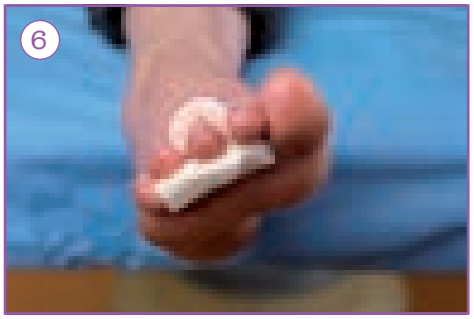
1. Cut a 25mm piece of **Hapla Tofoam BX** from the overlapped part of the tubular material.

2. Cut a length of **Haplagauz Size 01** long enough to form a loop around the toe. Put the Tofoam into the applicator and push it centrally within the tube of Haplagauz.

3. Hapla Gold Felt 5mm is cut and bevelled to the web space of the 2nd to 4th toes. Cut enough felt so that it can be doubled over.

4. Pierce two holes in the Hapla Gold Felt.

5. Each end of the Haplagauz strap is pushed through the holes in the felt and secured onto the felt's adhesive surface. The felt is then folded in half and the loose edges of Haplagauz trimmed away.



6. Push the Toe Prop over the toe with the felt underneath the toes.

The Toe Prop pad is used to maintain flexible clawed toes in a straight position.

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Action Learning Sets: A Way Forward for Clinical Supervision in Private Practice Podiatry

Part I: Understanding the concept of Clinical Supervision

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

Introduction

This two-part article explores the concept of Clinical Supervision and describes a possible realistic way forward for the foot health clinician working independently in private practice. Part I will explore the concept of Clinical Supervision with Part II looking in a more detailed way at Action Learning Sets and their potential for the Private Practitioner in foot health.

Clinical Supervision is not new and literature has been discussing its benefits to healthcare delivery for over 20 years. Much of the earlier papers and studies stem from practice related to disciplines such as nursing, psychotherapy and counselling, with less being focused on medicines and areas like podiatry. Indeed, from personal experience, it is very evident that different professional groups embrace the practice of clinical supervision with varying degrees of enthusiasm and commitment. In part, this may be down to the confusion over the terminology itself.

So, what is Clinical Supervision?

Defining Clinical Supervision

In examining and dissecting the term "clinical supervision" in its raw form, it becomes apparent where some of the challenge lies. Online dictionary definitions of the separate elements are outlined in Table 1.

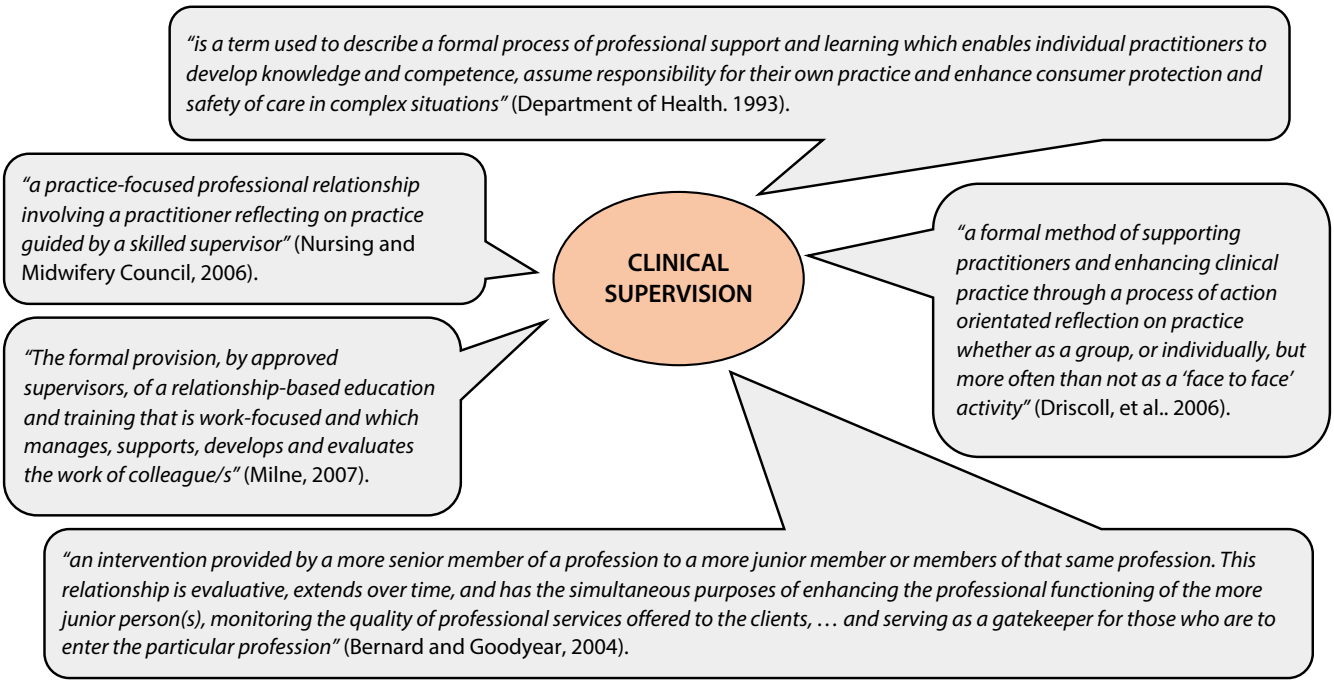
From this, it would seem that a person undergoing Clinical Supervision is being closely and actively watched performing activities involving the delivery of patient-facing care and treatment, with associated correction and education. However, the reality is there are many different approaches to Clinical Supervision and these vary significantly in terms of their methodology and, to some degree, their ethos. Indeed, the style and the content of what is learnt can be affected by the environment and by the model chosen (Kilminster and Jolly, 2000). Creaner (2013) suggests that trying to articulate Clinical Supervision is not easy and this is certainly clear from the many definitions in literature (See Figure 1).

Table 1: dissecting "clinical supervision" terminology

Clinical	"relating to the observation and treatment of actual patients rather than theoretical or laboratory studies" (dictionary.com)
	"used to refer to the medical work or teaching that relates to the examination and treatment of ill people" (Cambridge Dictionary)
Supervision	"the action of supervising someone or something" (dictionary.com)
	"the act of watching a person or activity and making certain that everything is done correctly, safely, etc (Cambridge Dictionary)

The definitions do, however, have overlapping and common themes such as education, learning and support but there are also some distinct differences. Notable is the notion of a hierarchical relationship in some which is absent in others and a sense that the process is very formalised and monitored. This focus mirrors the use of the word "supervision" in the title as it seems to infer a degree of management. The lack of consistency here in relation to this term could be a major contributor to some of the misunderstanding and widespread variation. The "clinical" aspect seems one of the more unifying threads throughout, with connections to work and practice. Indeed,

Figure 1: definitions of Clinical Supervision



it appears essential that prioritising the client and their treatment as the central focus is key. Reassuringly it straddles most designs of Clinical Supervision and it appears that in many situations it can be a mechanism for improving practice and the effectiveness of care (Snowden et al. 2020). However, Snowden et al. (2017) also indicate that its effectiveness in podiatry was less clear than in some other Allied Health Professional roles.

Key Characteristics

Perhaps amidst the confusion, it is important to consider what key characteristics contribute to Clinical Supervision. More historically, Proctor (1987) suggested that Clinical Supervision should have three aspects of directions. These are: formative (educative), normative (managerial) and restorative (supportive). This structure is often still used for developing policies around Clinical Supervision with good degrees of success (Turner and Hill, 2011), but the hierarchical element is still present in terms of the normative stance. Scaife (2001) alludes to the possible power differentials that can occur in the relationship of supervisor/supervisee and it could be argued that forming a system where the facilitator is more senior has the potential for other issues to arise and possibly cloud the experience.

More recently, Creaner (2013) has not only identified the need to keep the client central, but has also suggested that Clinical Supervision needs to be "helpful and validating" with the supervisee feeling able to bring doubts, concerns and subsequently learn from mistakes as part of their development. This could support, therefore, the benefit of keeping Clinical Supervision less managerial and more reflective and nurturing. Indeed, Fowler and Chevannes (1998) highlight the need to balance reflection versus direction particularly with individuals who are new to the process or their learning environment. This is further expanded on by Allen et al. (2010) who discuss "high challenge: high support" to create motivation to move combined with enablement to succeed. They emphasis that Clinical Supervision does not necessarily need to be based on hierarchy or performance and that it should certainly not be a policing exercise or conversely a counselling session. The focus should remain on lifelong learning, professional practice and support.

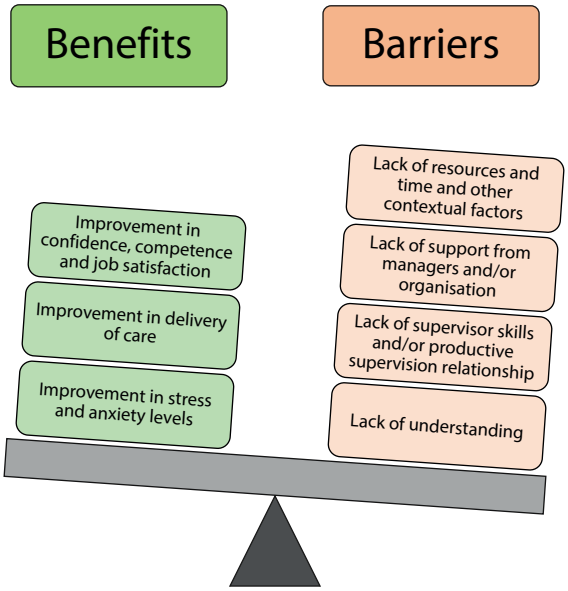
IT IS EVIDENT THAT THE WAY CLINICAL SUPERVISION IS IMPLEMENTED IS VERY VARIABLE AND OPEN TO INTERPRETATION

It is evident that the way Clinical Supervision is implemented is very variable and open to interpretation, but perhaps Snowden et al.'s (2020) research is useful here in that it identifies key themes that Allied Health Professionals found important. They expressed the need for the organisation to be on board with the process and this meant providing a suitable environment, a skilled supervisor and prioritising the clinical supervision as important. Also identified was the supervisory relationship, a focus on professional development and, very importantly in terms of this discussion, a flexible approach in terms of the models and processes used.

Challenges and Benefits

Whatever the process or system used, there seems to also be some consistency in the barriers and benefits to undertaking Clinical Supervision (see Figure 2). Whether the individual engages with the process and moves forward with it may depend on the balance of barriers and benefits. This undoubtedly will be influenced by previous experience, by personal attitude to such approaches to learning, and also by the individual work context.

Figure 2: Barriers and Benefits of Clinical Supervision

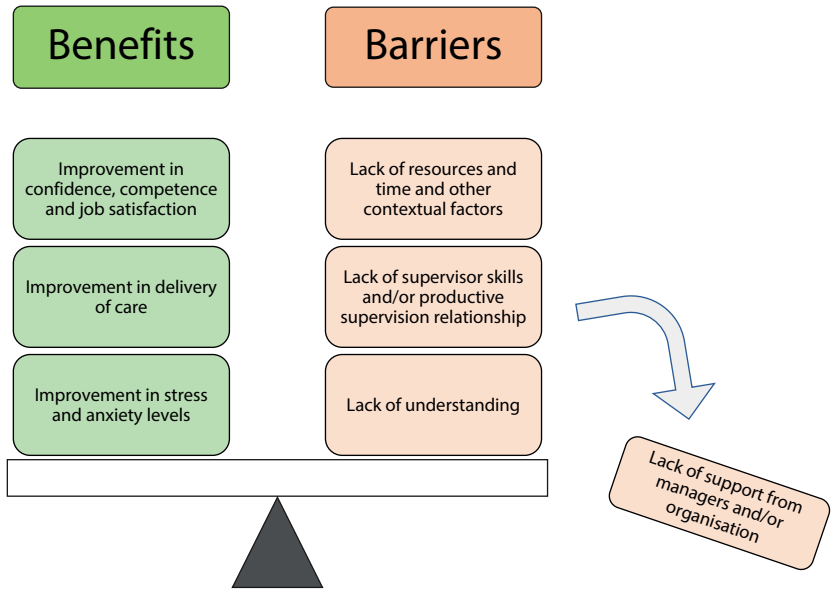


Perhaps the best way to view Clinical Supervision is as an adjunct to the day-to-day work which gradually becomes embedded and normalised over time. Basheer et al. (2018) articulate clearly the need to be creative in how healthcare professionals continue to learn despite the busy and complex environment which often causes tensions between education and service-delivery. Clinical Supervision often utilises terminology like "scaffolding" for developing learning (James et al. 2008), but ironically, it would seem important to realise that for some the scaffold may seem less rigid and be more like a trellis clinging to a wall or fence and wavering in the wind. Indeed, Allen et al. 2010) suggest the Clinical Supervision can help to reduce emotional load and build self-esteem which arguably increases the individual's level of resilience. Strengthening the individual and their ability to "cling to the trellis" enhances the possibility of learning and subsequent practice development. The overall outcome therefore may be improved practice. Allen et al. (2018) also describe the opportunity provided for challenging existing thinking through debate and possibility that clinicians can therefore see solutions to problems.

Enabling Clinical Supervision in Private Practice Podiatry

So far in this article the complexity and variation of Clinical Supervision has been explored and this next section moves to consider its role and possibilities in Private Practice Podiatry. Kilminster and Jolly (2000) suggest that one of the most important factors in being successful with the concept is the element of individual choice, and this seems particularly pertinent for the Private Practitioner. The context of Private Practice and in particular the individual working alone influences that choice. Creaner (2013) reiterates this idea describing how context is important from two angles; it informs the supervision itself but it is also informed by the supervision. Private Practice brings different challenges to the working arena and these may influence not only how Clinical Supervision can be carried out but its focus.

Figure 3: Barriers and Benefits of Clinical Supervision – Private Practice



One interesting point is that the Private Practice foot health clinician may not be "managed" and this could be seen as a constraint. However, more positively, this could in fact be seen as a benefit (See Figure 3) with the balance of barriers versus benefits being equalised. The onus is placed firmly on the individual to ensure they embrace and enable Clinical Supervision to happen. Stark (2006) also talks about how organisational structures and associated tensions can prevent the success of forward movement by fear of upsetting the status quo. Again, this element and possible barrier is not evident in the same way with the autonomous, sole practitioner.

With the potential lack of management it also means that any drawbacks to a hierarchical approach are negated. Clinical Supervision can be based on a collaborative and/or peer design (Launer, 2015) or through networking (Wright and Scholefield, 1997) with the practitioner themselves having control over how they wish to proceed (Kilminster and Jolly, 2000). It would seem that the scales are definitely tipped favourably to introduce Clinical Supervision as an adjunct to practice through a relaxed, flexible but structured approach. One such structure is that of Action Learning Sets.

Action Learning Sets

Action Learning Sets (ALS) have been around for some time and are described as "a continuous process of learning and reflection, supported by colleagues with the intention of getting things done" (McGill and Beatty, 2001; 11). They can be used as a framework for Clinical Supervision (Nursing Times, 2012) which is not embedded in a managerial format and which uses challenge and reflection to help individuals to find solutions to clinical dilemmas. The way ALS fit with Clinical Supervision is illustrated in Figure 4.

Action Learning Sets seem perhaps less formal than some Clinical Supervision formats, but they do have a clear structure and format. The way to approach starting an Action Learning Set group and the necessary facilitation will be detailed in Part II in the next journal.

Figure 4: Action Learning and Clinical Supervision comparison

Action Learning	Clinical Supervision
"A method of both individual and organisational development based upon small groups of colleagues meeting over time to tackle real problems or issues in order to get things done - reflecting and learning with and from their experience and from each other as they attempt to change things" (Edmonstone, 2011 p 5)	"an accountable process which supports, assures and develops the knowledge skills and values of an individual group or team" (Skills for Care, 2007) The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work (Care Quality Commission, 2013)

Conclusion

Clinical Supervision can be seen as a "trellis" of support which gives healthcare clinicians a structure to "cling" to amidst the challenges of their working environment. Healthcare delivery results in individuals dealing with complex situations, sometimes with very little space or time to reflect, and Clinical Supervision can provide that opportunity. Benefits tend to include a transition to an approach of lifelong learning which ultimately improves practice through nurturing personal and professional growth. Barriers do exist and the choice of how to implement Clinical Supervision can be confusing. Perhaps the most important element is to acknowledge that the individual must have some control over this and select a direction which fits the context of their working practice and their learning needs.

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

virtual (zoom) and in-house

in-house only

Neurological & Vascular Assessment

7th January 2021 - Fully Booked

27th May 2021

10.00am - 4.30pm

Lecturer: Andrew Hill

MEMBERS FAVOURITE

Neurological and Vascular assessments form a fundamental part of good practice and offer an invaluable screening tool for practitioners, patients and whoever the patient is referred onto depending on their results. This workshop looks to discuss both of these body systems in detail with a view on how and why they go wrong as well as what observable signs and symptoms may present to practitioner. This will be further enhanced by an in-depth discussion about the assessments we can conduct as practitioners and how to document any findings.

Cost: £56.00

Medical Emergency Procedures Courses

16th January 2021 - Fully Booked

13th February 2021 - Fully Booked

14th February 2021 - Fully Booked

6th March 2021 - Fully Booked

7th March 2021 - Places Available

20th March 2021 - Places Available

21st March 2021 - Places Available

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

13th & 14th January 2021
20th & 21st July 2021

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

17th & 18th February 2021
28th & 29th September 2021

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

17th & 18th March 2021
24th & 25th November 2021

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

MEMBERS FAVOURITE

What is the best way to deal with Onychocryptosis?

20th January 2021 - Fully Booked

8th June 2021 - Fully Booked

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

Sports Injuries

Foot Problems in the Athletic Patient

28th January 2021

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop deals with the most common occurring sporting injuries and encompasses the activity induced injuries that occur in the lower extremity. It aims to incorporate the different sports induced pathologies that occur and diagnostic examinations which will aid the practitioner in their practice. In conjunction with the course, it also prepares the practitioner to understand what short and long term management plans for the patient consist of.

Cost: £56.00

What can go wrong in Diabeties?

3rd February 2021

10.00am - 4.30pm

Lecturer: Andrew Hill

Diabetes continues to affect more and more of the population. Improved diagnostic skills and treatment breakthroughs are encouraging. However, the condition remains a serious one and patients and practitioners alike need to be focused and dedicated in minimizing the impact on the patient's health. In this workshop we will be looking at the pathophysiology of diabetes and its associated complications such as neuropathy, ischaemia and infection.

We will also be looking at development of ulcers, osteomyelitis and biomechanical problems occurring as a result of diabetes. The workshop will also address screening the high risk foot, patient education, treatment options, and referral pathways as well as how this affects your practice.

Cost: £56.00

'If it is wet, dry it... if it is dry, wet it'

A Dermatology Update

5th February 2021

MEMBERS FAVOURITE

10.00am - 4.30pm

Lecturer: Belinda Longhurst

This presentation is refresher on the role and function of our largest organ: the skin. We examine cause, manifestation and evidence-based treatments of common – and not so common – skin conditions we encounter in practice. From anhidrosis to worrying rashes, we explore the important role of the practitioner in helping patients control and prevent dermatological complaints of the foot.

Cost: £56.00

How Good Is Your Clinical Practice?

8th March 2021

10.00am - 4.30pm

Lecturer: Andrew Hill

This workshop will focus on the important legal issues surrounding your practice, ensuring that you are protecting yourself as well as your patients.

In this workshop we will look at:

- Issue of consent: Just who is able to give informed consent?
- Record keeping: Data protection responsibilities and legal implications of poor record keeping
- Review of the SOAP note format
- Assessment protocols and referral pathways / responsibilities
- Infection Control Practices: Disinfection procedures; waste disposal; health and safety; sterilization etc

All of these key areas will be looked at in both the context of clinic-based and domestic-based practice.

Cost: £56.00

Padding and Taping

MEMBERS FAVOURITE

Alleviate Pain in Minutes

11th March 2021 - Fully Booked

10th September 2021 - Limited Places Available

10.00am - 4.30pm

Lecturer: Andrew Hill

Would you like a hands-on practical workshop learning how to alleviate your patient's pain in just 5 minutes, but are worried about delving into biomechanics?

Padding and Taping can offer fantastic results for short and medium term pain relief and is the basis of lower limb biomechanics.

The following padding and tapings are taught:

Padding

- Plantar cover
- 'U' and winged plantar cover
- Plantar metatarsal pad
- Crescent pad
- Horseshoe pad
- Oval pad
- Shaft pad including extended shaft pad

Taping

- Low dye
- High dye (ankle instability)
- Plantar fascial
- Posterior tibial tendonitis
- Achilles tendonosis
- Ray stabilisation

Cost: £56.00

Nail Reconstruction Techniques

20th March 2021

09.00am - 4.30pm

Lecturer: Deborah Rockell

Focused on from a pathological podiatry angle, for treating patients with a nail in one or more of the following categories:

- Minimal nail due to trauma
- Partial nail / total nail avulsion disaster
- Onychogryphotic nail
- Onychomycotic nail

Using gel cured by UV light, the nail reconstruction takes less than 10 minutes to administer in your practice and will change the appearance of the nail completely. This is the only course offered anywhere from a purely podiatry perspective and will change your patient's anxiety about their toenail appearance.

NB: Course fee includes a full Gel kit including lamp. Max. 6 students per course.

Cost: £285

Gait Analysis

A Step-by-Step Approach

25th March 2021 - Limited Places Available

10.00am - 4.30pm

Lecturer: Andrew Hill

What is Gait Analysis? What can it tell us? What do different walks mean potentially to me as a clinician? How do commonly occurring pathologies impact on gait? How can I undertake gait analysis on my patient? Gait analysis is a great tool to use to identify potential underlying pathomechanics and the smallest of interventions can prevent pain and improve quality of life. Come for a fun filled day and learn the basics within a small and friendly group of colleagues. What does your gait say about you?

Cost: £56.00

Simple Insoles

8th April 2021

10.00am - 4.30pm

Lecturer: Andrew Hill

MEMBERS FAVOURITE

Would you like to be able to increase your scope of practice and revenue?

Wish you could make a simple insole for your patients and offer something more permanent than padding alone?

Now is your chance to learn how to make simple insoles for your patients in a fun and supportive environment. This one-day CPD Workshop will focus on how to make insoles for your patients, including which materials to use, and techniques for measuring, making and fitting them for your patients whilst they wait. All materials are included when on the Workshop and attendees will get to take the designed insoles home.

Cost: £75.00

An age-old problem: The Podo-geriatric Foot

14th April 2021

10.00am - 4.30pm

Lecturer: Andrew Hill

As the population continues to age, there is ever more demand for healthcare services. As healthcare professionals look to provide the best care possible for people as they get older, foot care is an area that will continue to see huge demand. The aging foot provides often unique challenges and pathologies that are not seen in other demographics whilst still suffering from ailments that affect feet of any age. This workshop looks to assess the considerations of treatment in the geriatric foot and will be of benefit to practitioners irrespective of clinical experience.

Cost: £56.00

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

MEMBERS FAVOURITE

26th April 2021

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?

MEMBERS FAVOURITE

7th May 2021

10.00am - 4.30pm

Lecturer: Andrew Hill

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

18th May 2021

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?

11th June 2021

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 conditions – an introduction to dermoscopy

NEW

14th June 2021

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

Verrucae & Tumours

Recognition and Management

9th August 2021

10.00am - 4.30pm

Lecturer: Belinda Longhurst

MEMBERS FAVOURITE

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

What makes a foot 'High Risk'?

2nd July 2021

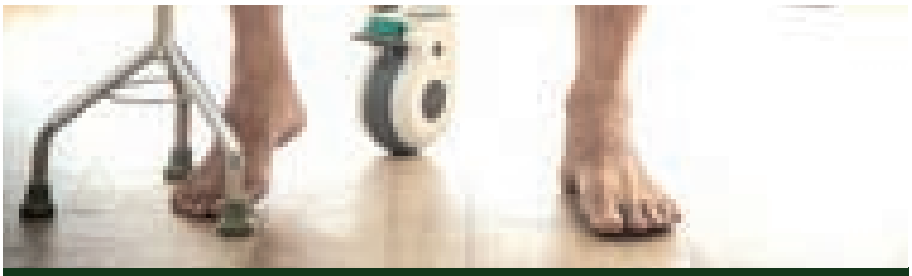
10.00am - 4.30pm

Lecturer: Debbie Rockell

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?

13th July 2021

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

Fostering Improvements in Patient Health Behaviour

12th August 2021

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?

23rd August 2021

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 Type Of Joint Problem Does Your Patient Have?

16 September 2021

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

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

Exploring Metatarsalgia

1st September 2021

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

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

8th October 2021

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

The Sharp End of the Job

Scalpel Debridement & Enucleation Technique

19th October 2021

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

Common Foot Conditions

Things that you cannot afford not to know about

16th November 2021

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

Are you promoting evidence-based practice?

3rd November 2021

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

Tropical Diseases of the Foot

1st December 2021

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

How Would You Look After A Patient With Chronic Pain?

10th December 2021

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

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(Online only)

- Infection Control
- Padding and Taping
- Dermatology
- Rheumatology
- Biomechanics
- Podopaediatrics

Cost: £45 each

Fostering improvements in patient health behaviour

NEW

(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

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

Anatomy, Cell Biology and Physiology Series: 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.

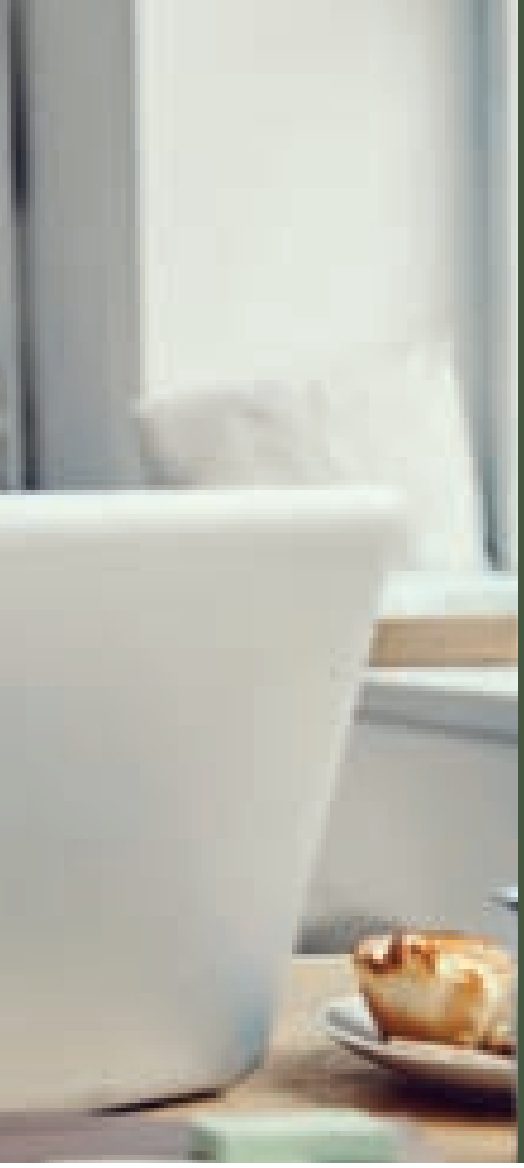
Cost: £45

Anatomy, Cell Biology and Physiology Series: 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



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

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

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

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

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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

BEST SELLER

Commonly Used Medications And Their Side Effects

(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

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

BEST SELLER

Common Conditions Affecting The Elderly

(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

BEST SELLER

Is It Fungal Or Isn't It?

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

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

BEST SELLER

Treating the Persistent Verruca CPD

(Online only)

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

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DVD Onychocryptosis

Have you been treating it correctly?

Onychocryptosis has always been widely regarded as one of the most common nail problems that face foot health practitioners and Podiatrists.

In this DVD we will be exploring exactly what constitutes the term Onychocryptosis and its causes. This CPD will look at the structure and function of nails, the various conditions that pre-dispose patients to Onychocryptosis, as well as the correct management for this very common condition.

(DVD) Approx. 45 minutes.
Best viewed in 4.3 ratio

Cost: £65

DVD Infection Control And Your Practice

Don't Get Caught Out!

An important part of any healthcare practice is that of infection control. The risk of healthcare workers becoming infected or passing on infection to others is greater than in most other professions. This is because of the greater number of potentially infective people that healthcare workers come into contact with. This DVD looks at the different types of infections, the mode of transmission and infection, all the way through to the best forms of prevention, as well as what to do in the event of exposure to infection.

The following areas are covered:

- Infectious Disease
- The Nature of 'Resistance'
- Blood-Borne Infections
- Common Pathogens affecting the Feet
- Patient-Practitioner Cross Infection

(DVD) Approx. 45 minutes.
Best viewed in 4.3 ratio

Cost: £65

British Chiropody & Podiatry Association

The British Association of Foot Health Professionals

REGIONAL BRANCHES & CONTACT DETAILS

Hon. President

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120 Bull Lane, Rayleigh, Essex SS6 8NQ

East Anglia Branch

Chairman: Alex Hepburn
alexhepburn30@hotmail.com

Treasurer: Deborah Hart
deborahhartuk@yahoo.com

Venue: The Army Reserve Centre,
Blenheim Camp, Newmarket Road,
Bury St. Edmunds IP33 3SW | 9am – 12:30pm

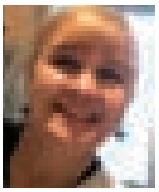
East Midlands Branch

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

Secretary: Julie Astill
thefootings@gmail.com

Facebook: East Midlands British Chiropody & Pod Assoc + FHPs (unofficial)

Venue: Forest Hill Golf & Conference Centre,
Markfield Lane, Leicester LE9 9FH | 10am-1pm



Essex & East London Branch

Chairman: Deborah Mercer
deborah.mercer2@btinternet.com

Vice Chairman: Michele Pyne
michele.pyne@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: Graham Seath
foothealthcare@yahoo.co.uk

Secretary: Sally Johnston
sallyjohnston76@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: Angela Fenton
angela_fenton@hotmail.co.uk

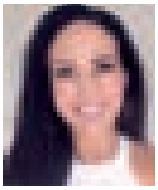
Venue: Ormskirk Civic Hall, Southport Road,
Ormskirk L39 1LN
12noon – 3:30pm

Scottish Branch (Dundee)

Chairman: James Fisher
shirleyfisher411@btinternet.com

Secretary: Fiona Morgan
fiona.morgan22@btinternet.com

Venue: Diocese of Dunkeld,
24-28 Lawside Road, Dundee DD3 6XY
9am – 4:30pm



South East Branch

Chairman: Clare Dicker
clare_dicker@hotmail.co.uk

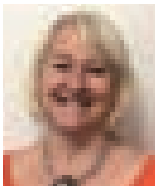
Venue: Copthorne Hotel Gatwick,
Copthorne Way, Copthorne,
West Sussex RH10 3PG
9am – 4pm

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

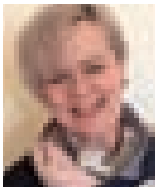


Thames Valley Branch

Chairman: Sue Davies
sue.davies63@yahoo.co.uk

Secretary: Lindsey Webster
lamweb@hotmail.com

Venue: Boyn Hill Cricket Club,
Boyn Grove, Highway Road,
Maidenhead, Berkshire SL6 5AE
7:30pm – 9:30pm



West Midlands Branch

Chairman: Elena Serafinas Broom
elenapodiatry@hotmail.com

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

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William J. Liggins (Bill)
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