

**GO PUBLIC!**



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## **Podiatry Referral Guidelines**

**Podiatry Clinic Location:** Valley Specialty Center 2nd floor  
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**Podiatry Clinic Phone:** (408) 793-2520

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**This information is designed to aid practitioners in making decisions about appropriate medical care. These guidelines should not be construed as dictating an exclusive course of treatment. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institutional type of practice.**

### **E-CONSULT DISCLAIMER:**

**E-consults are based on the clinical data available to the reviewing provider, and are furnished without benefit of a comprehensive evaluation or physical examination. All advice and recommendations must be interpreted in light of any clinical issues, or changes in patient status, not available to the reviewing provider. The ongoing management of clinical problems addressed by the e-consult is the responsibility of the referring provider. If you have further questions or would like clarifications regarding e-consult advice, please contact the reviewing provider. If needed, the patient will be scheduled for an in-office consultation.**

**All URGENT consultations require provider-to-provider communication. If your patient has a medical emergency, please direct them to the closest emergency room for expedited care.**

**\*\*\* Podiatry, a division of the department of Surgery, is a sub-specialty that provides outpatient medical and surgical care of the foot and ankle to**

**patients of all ages. To obtain an E-Consult, please send a referral via Healthlink, as is appropriate, using the following guidelines. The patient issue will be handled either with an advice for care or an approved referral for the patient to be seen in clinic. \*\*\***

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## FOR EMERGENCY DEPARTMENT OR URGENT CARE PROVIDERS

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To allow us to provide access to our division, we ask that non-urgent diagnoses be handled initially in the primary care setting. Patients who have no assigned primary care provider should be referred to panel management ([panelmanagement@hhs.sccgov.org](mailto:panelmanagement@hhs.sccgov.org)).

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## BUNION / HALLUX ABDUCTO VALGUS / JUVENILE BUNION / TAILOR'S BUNION

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### 1. Background

- a. A bunion is a “bump” on the outer edge of the great toe (hallux) which forms when the bone or tissue at the joint moves out of place. It is characterized by medial deviation of the first metatarsal and the lateral deviation of the hallux. A tailor’s bunion (bunionette) is a lateral prominence of the 5<sup>th</sup> metatarsal head.
- b. It is generally believed that there is a genetic component to the development of a bunion and tends to run in families specifically those who have foot types prone to its development. Bunions may also develop in cases of injury, inflammatory joint disease or arthritis. Symptoms consisting of pain and swelling in closed shoes are often aggravated by ill-fitting shoes or high-heeled shoes.

### 2. Pre-referral evaluation and treatment

- a. Testing
  - i. X-ray of the foot must be weight-bearing.
- b. Conservative management
  - i. Shoe modifications: Avoid ill-fitting tight shoes or shoes that are high-heeled.
  - ii. Pain management: Give a trial of anti-inflammatory medication to alleviate pain symptoms. Consider Acetaminophen, topical analgesic creams (capsaicin or methyl salicylate), mild NSAIDs (Trisilate, Disalcid), Analgesic (codeine), Potent NSAIDs (Ibuprofen, Naproxen)
  - iii. Consider OTC arch supports, padding or toe splints/ separators: These may be purchased in medical supply stores.
  - iv. Avoid activities that will cause pain including standing for long periods of time.

### 3. Indications for referral

- a. Recalcitrant pain despite attempts at conservative treatment and if patient is interested in surgical correction.

- i. Recommendation: Do not suggest surgical intervention unless evaluated and recommended by Podiatry.
- b. Do not refer:
  - i. Patients who refuses to modify their shoes or have tried a trial of pain medication.
  - ii. Patient requesting surgery for cosmetic reasons.
  - iii. Patients with contraindication to surgery including, but not limited to compromised vascular status, infection risk, challenging social status (homelessness, drug use, lack of support), unrealistic expectations or difficulty in complying with instructions or post-operative care.

#### **4. Please include the following with your referral**

- a. Results of X-rays of the foot as indicated, preferably weight-bearing.

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## **FOREIGN BODY IN THE FOOT**

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### **1. Background**

- a. Patient may often step on a sharp object that penetrates the foot including but not limited to glass, wood shrapnel, a needle, a piece of wire, a thorn or any other sharp object especially when walking barefoot.

### **2. Pre-referral evaluation and treatment**

- a. Testing
  - i. X-ray to rule out foreign body.
- b. Conservative management
  - i. Off-weight the foot with crutches if significantly painful.
  - ii. Pain management: Give a trial of anti-inflammatory medication to alleviate pain symptoms. Consider Acetaminophen, topical analgesic creams (capsaicin or methyl salicylate), mild NSAIDs (Trisilate, Disalcid), Analgesic (codeine), Potent NSAIDs (Ibuprofen, Naproxen)
  - iii. Antibiotics if there are signs of infection
  - iv. Update tetanus shot as is applicable

### **3. Indications for referral**

- a. Patient with pain and/or infection with or without abscess in need of surgical excision.
  - i. Not all cases of foreign body in the foot need to be surgically removed or is it always possible to be removed.
  - ii. If there is significant pain or signs of infection, the patient needs to be evaluated in a timely manner.

- iii. Please order an x-ray to rule out whether a foreign body is actually present and in need of excision.
  - 1. If a foreign body is present, please contact the on-call Podiatrist for triage and scheduling as is appropriate.
- b. Do not refer:
  - i. Patient with known foreign body but without pain or signs of infection.
  - ii. Foreign body has been present in foot for greater than 3 months

**4. Please include the following with your referral:**

- a. X-ray of foot, non-weight-bearing.

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## **GANGLIONIC CYST, JOINT OR TENDON**

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### **1. Background**

- a. A non-neoplastic soft tissue mass that may occur in any joint or tendon of the foot. It is the distension of a weakened joint capsule or tendon sheath by leakage of synovial fluid into the surrounding tissue often caused by trauma, repeated mechanical stress or inflammation.
- b. They are rarely painful until they become large and are then pressed upon by closed footwear. They tend to change in size over time and are often observed and treated conservatively.

### **2. Pre-referral evaluation and treatment**

- a. Conservative management
  - i. Warm compresses may help to liquefy the material and cause reduction in size of the mass.
  - ii. Avoid tight shoes. Loosen shoe strings as necessary.

### **3. Indications for referral**

- a. A non-resolving mass of foot that continues to enlarge causing pain or an inability to wear closed shoes.
- b. Patient in need of aspiration or surgical excision.
- c. It is best to observe the mass for changes over time and to try conservative treatment because of the high recurrence rate with aspiration and surgical excision.

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## GANGRENE OF FOOT

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### 1. Background

- a. Dead or dying tissue in the foot that occur because the local blood supply to the tissue is either lost or is inadequate to keep the tissue alive (peripheral arterial disease). The changes in the foot involves black, necrotic scabs developing into larger necrotic ulcers that often lead to necrosis of entire toes or parts of the foot. There are two types of gangrene referred to as dry and wet. Most cases of dry gangrene are not infected while all cases of wet gangrene are considered to be infected, almost always by bacteria. Common causes of gangrene include diabetes, smoking or arterial blood clots/ vasculitis.
- b. **Wet gangrene** is serious because if left untreated, the patient usually develops sepsis and is risk of loss of limb as well as loss of life. Early stages of wet gangrene may include signs of infection, aching pain with swelling, dependent rubor or pallor if the area is raised, coolness on the skin surface, necrotic ulceration, and a crackly sensation or bogginess when the skin is pressed due to gas in the tissue.
- c. **Dry gangrene**, if it does not become infected and progress to wet gangrene, usually does not cause sepsis. These patient will need urgent vascular intervention to evaluate for critical limb ischemia.

### 2. Pre-referral evaluation and treatment

- a. Testing
  - i. Expedited non-invasive vascular testing
- b. Conservative management for **dry gangrene**
  - i. Protect the foot and do not get wet.
  - ii. Betadine may be applied to the margins when there are open wound areas.
  - iii. Order non-invasive vascular testing consisting of arterial duplex and ABIs with TCPO2.
  - iv. Send urgent referral to Vascular Surgery.

### 3. Indications for referral

- a. Patients at risk for limb loss in need of wound care.
- b. Patients with dry gangrene are not surgical candidates unless evaluated or treated by Vascular Surgery or unless infection supersedes the vascular compromise.
- c. Do not refer
  - i. Patients with **wet gangrene**.

1. This is a medical emergency with a patient in need of hospitalization for sepsis and risk for limb loss. Send to the Emergency Room.
  2. Patient will need urgent surgical intervention.
- ii. Patients without urgent referral to Vascular Surgery.

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## HAMMERTOE DEFORMITIES / TOE CONTRACTURES

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### 1. Background

- a. Toe contractures may occur due to poor-fitting shoes that puts the toe into a bent position (short shoes, narrow shoes, high-heeled shoes), muscular/ tendinous imbalances, concomitant bunion deformity, arthritis, neuro-muscular conditions or trauma.
- b. Toe contractures may occur at the proximal interphalangeal joint (hammertoe), the distal interphalangeal joint (mallet toe) or both joints (claw toe) as well as at the metatarsophalangeal joint.

### 2. Pre-referral evaluation and treatment

- a. Testing
  - i. weight-bearing x-ray of foot.
- b. Conservative management
  - i. wear shoes with wider/roomier toe box
  - ii. OTC cushions or pads

### 3. Indications for referral

- a. Contracture of digit, at any joint level, with or without hyperkeratosis in need of conservative recommendations or surgical intervention.

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## HYPERKERATOSIS (calluses / corns / clavi / porokeratomas)

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### 1. Background

- a. A callus is an area of hard and thickened skin, discrete or diffuse, developed in response to friction, pressure or irritation. Pain is often why a patient seeks treatment.
- b. In diabetics or patients with loss of protective sensation/ vascular insufficiency, calluses often lead to ulcerations if left untreated.

### 2. Pre-referral evaluation and treatment

- a. Conservative management
  - i. Use lotion or anti-keratolytics (only if non-DM) to soften callused areas.
  - ii. Use OTC soft/gel insole to off-weight in shoes.
  - iii. Use pumice stone or shaving devices (only in non-DM)



### **3. Indications for referral**

- a. Painful skin lesions that the patient is not able to self-treat.
- b. Medically at-risk patients (DM, PVD, geriatric, connective tissue disease, paraplegics/quadriplegics).
  - i. Please exam feet of all diabetics or at-risk patients for calluses which may be at risk for ulcerations.
- c. Painful lesions over joints or bony prominences.
- d. Do not refer
  - i. Healthy patients with minimal hyperkeratosis.
  - ii. Cosmetic reasons.
  - iii. Diffuse keratosis over large surface areas without fissuring or ulcerations.

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## **NAIL DYSTROPHY / ONYCHOMYCOSIS / ONYCHOGRYPHOSIS**

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### **1. Background**

- a. Nail dystrophy is a condition where the nail is severely damaged either due to a traumatic event or fungal infection. The nail loses its shape or gets partially or completely destroyed often causing pain, ulcerations or difficulty walking.
- b. Onychomycosis is a common cause of nail changes when fungus on the skin invades under the nail and leaves it thickened, discolored and brittle.

### **2. Pre-referral evaluation and treatment**

- a. Conservative management
  - i. Consider shoe modification by wearing shoes that are wider or have a roomier toe box.
  - ii. Treat the underlying tinea pedis with a topical cream. See conservative treatment for tinea pedis.

### **3. Indications for referral**

- a. Patient with medical necessity including pain, difficulty walking or gait abnormality
- b. Patient with DM, PVD, neuropathy or immune-compromised state at risk for infection, ulceration, amputation or loss of limb.
- c. Patient in need of fungal nail culturing for definitive treatment.
- d. Do not refer
  - i. Young, healthy patient with minimal pathology.
  - ii. Patient with normal nails.
  - iii. Patient with limited mobility but without limb risk such as obesity, chronic back pain, RA or OA.
  - iv. Patient with poor hygiene only.
- e. These patients must adhere to Medicare guidelines which require diagnosis of underlying systemic disease with compromising factors

(neuropathy, PVD, anticoagulation therapy) and symptom complaint (pain, difficulty walking, altered gait).

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## NEUROMA / MORTON'S NEUROMA / PLANTAR NEUROMA

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### 1. Background

- a. A benign growth of nerve tissue found in the inter-metatarsal spaces, frequently between the 3<sup>rd</sup> and 4<sup>th</sup> toes (Morton's neuroma). It may be caused by biomechanical deformities, trauma, improper footwear (tight or high-heeled shoes) or repeated stress in the ball of the foot. Patient generally experiences pain and swelling between the affected toes ("feels like stepping on a stone") along with tingling and some numbness.

### 2. Pre-referral evaluation and treatment

- a. Conservative management
  - i. Avoid tight, ill-fitting shoes or high-heeled shoes.
  - ii. Use a soft/gel insole to off-weight.
  - iii. Pain management: Give a trial of anti-inflammatory medication to alleviate pain symptoms. Consider Acetaminophen, topical analgesic creams capsaicin or methyl salicylate), mild NSAIDs (Trisilate, Disalcid), Analgesic (codeine), Potent NSAIDs (Ibuprofen, Naproxen).

### 3. Indications for referral

- a. Forefoot pain with increasing paresthesia or pain into digits 2, 3, 4 or in the ball of the foot.
- b. Patient will be seen for injection therapy.

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## PARONYCHIA (ingrown nail)

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### 1. Background

- a. An ingrown nail presents when the nail grows into the peri-ungual flesh. This occurs when the nail is thickened or incurvated but may also occur as a result of trauma, ill-fitting shoes or improper grooming of nails.

### 2. Pre-referral evaluation and treatment

- a. Conservative management
  - i. Soak BID with warm water and Epsom salt
  - ii. Avoid ill-fitting or tight shoes.
  - iii. Oral antibiotics only if indicated.
- b. Recommendations

- i. Avoid wearing tight or ill-fitting shoes.
- ii. Cut nails straight across.
- iii. Soak in warm water with Epsom salt when first painful.

### 3. Indications for referral

- a. Persistent pain with ingrowing nail border(s) and swelling with or without redness or drainage. Please **indicate whether problem is acute or chronic**.
- b. Chronic pain due to thick, dystrophic nail borders or deeply incurvated nail borders with or without deformity.
- c. Diabetic patient or at risk patients with nail pain or concern for infection.
  - i. Patient with diabetes or neurovascular compromise should be seen urgently to avoid complications that may lead to limb loss. Please send an urgent referral.

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## PLANTAR FASCIITIS / CALCANEAL SPUR (heel pain)

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### 1. Background

- a. Plantar fasciitis is the most common cause of heel pain. It is pain and inflammation of the plantar fascia, which is a flat band of tissue that connects the ball of the foot to the heel bone and supports the arch. When the fascia is strained, it will weaken, become swollen and irritated or inflamed. It is common in middle-aged patient, especially those who are overweight, but is also common in younger patients who are on their feet excessively. Pain is usually in the morning on first step after rising out of bed. It tends to feel better with some stretching and walking.

### 2. Pre-referral evaluation and treatment

- a. Conservative management
  - i. Stretching of the fascia and icing of the medial heel.
  - ii. Stretching of the Achilles tendon and calf muscles.
  - iii. Avoid shoes that do not fit well or are worn out.
  - iv. Avoid walking, standing or running on hard surfaces.
  - v. If overweight, consider non-weight-bearing exercises such as exercise bike, weight-lifting with light weights while sitting on exercise ball, or water activities. Avoid long walks, running or walking on treadmills.
  - vi. Pain management: Give a trial of anti-inflammatory medication to alleviate pain symptoms. Consider Acetaminophen, topical analgesic creams capsaicin or methyl salicylate), mild NSAIDs (Trisilate, Disalcid), Analgesic (codeine), Potent NSAIDs (Ibuprofen, Naproxen).

### 3. Indications for referral

- a. Recalcitrant pain despite conservative management
- b. Do not refer
  - i. Patient requesting surgery for acute plantar fasciitis or to remove a spur. This is **not a surgical issue** unless all conservative treatment options have been exhausted over a period of at least a year.
    - 1. X-rays will often show evidence of plantar calcaneal spurring. This is usually not the main cause of the heel pain and surgical resection is not indicated. Please do not suggest to the patient that the cause of their pain is the heel spur and that surgery is the treatment. We will assess the appropriateness for any surgical intervention.

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## ULCERS OF THE FOOT

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### 1. Background

- a. A foot ulcer is an open sore that may be a shallow crater involving only the skin surface or it may be deep crater that extends through the full thickness of the skin. Often, it may progress to involving tendons, bone or other deep structures.
- b. The most common cause of ulceration is diabetes and peripheral arterial disease. In these patients, an ulcer that does not heal quickly or receive adequate wound care, it can easily become infected. 85% of every amputation is preceded by an ulcer in diabetics.

### 2. Pre-referral evaluation and treatment

- a. Testing
  - i. If deep probing wound, please order x-ray to rule out osteomyelitis.
  - ii. If patient has underlying peripheral vascular disease or evidence of dry gangrenous changes in foot, please send urgent referral to Vascular Surgery.
- b. Conservative Management
  - i. In cases of small superficial wounds (cuts) or open blisters, patients may initially wash the wound with liquid soap and warm water and then apply antibiotic ointment/ cover with band-aid or gauze.
  - ii. Observe for healing and signs of infection.
  - iii. Limit walking to off-weight wound area

### 3. Indications for referral

- a. All diabetics, patients at risk (neuro-vascular compromise), immune-compromised conditions or chronic non-healing wounds.
- b. Please **send a referral also to the Wound Clinic** for access to more immediate care.
- c. Call Podiatrist on-call to expedite care if urgent.

#### Revisions:

- April 2017, formatting
- October 2017, formatting