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Orthoughtics

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*podiatric*profile

Manhattan evokes images of heels clicking down Fifth Avenue, wing tips scurrying along Wall Street and athletic shoes pounding across Central Park. A place where people are on the go and on their feet. It's also a place where an unlikely partnership was born of a whim, and unconventional wisdom bred a thriving practice called Manhattan Podiatry Associates.

Drs. Steven P. Abramow and John E. Mancuso

John Mancuso and Steven Abramow were childhood friends who lived across the street from each other in Laurelton, NY. The Mancuso family moved away when the boys were ten, and they lost touch until their first day as freshmen at the New York College of Podiatric Medicine. Dr. Abramow recalls, "I saw the name John Mancuso on the class list, and I thought, could it be?" Adding to the irony of their reunion was the fact that Dr. Abramow had been studying predentistry at the University of Maryland when an ingrown toenail landed him in a podiatrist's office, introducing him to his future profession. Dr. Mancuso, on the other hand, always wanted to be a podiatrist. "I felt that the foot was a part of the body that the medical profession had left behind," he explained. "I chose podiatry because I wanted to make a difference in a growing profession. I wanted to add to its advancement." The two became fast friends and roommates until their graduation in 1980. Then their paths branched when Dr. Mancuso was accepted to the coveted Northlake Community Hospital Residency Program in Chicago and Dr. Abramow joined the Yale-affiliated West Haven VA Hospital Residency Program.

But fate intervened again when the two ran into each other one October weekend at a party in New York City. "At three o'clock in the morning the two of us were walking home and saw a "For Rent" sign in the window of a brownstone on 89th Street and Lexington Avenue," recalls Dr. Abramow. "John and I were destined to practice together."

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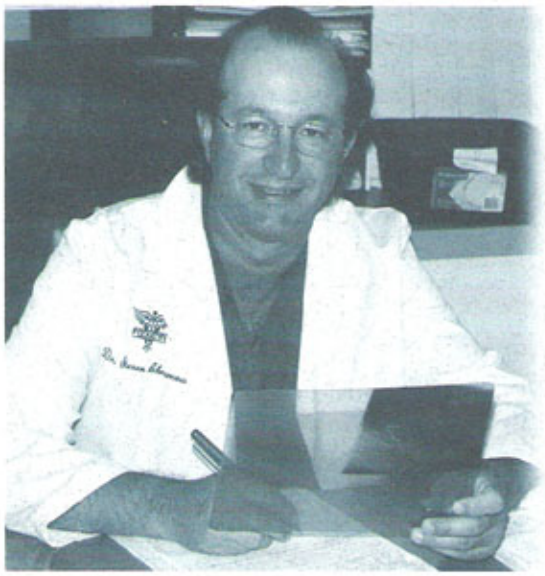
>
> *—Dr. Mancuso*

The two residents rented that brownstone, the first office of a partnership started with $50,000 in loans from banks and family. Dr. Abramow commuted from New Haven on weekends to build the office with his own hands, while Dr. Mancuso, still in Chicago, sent money. When the practice opened on July 7, 1981 the two doctors did everything - answered the telephone, made appointments, collected the money and paid the bills. By August they were in the black and in Sep-

—continued on page 2

tember they opened their first satellite office in Rego Park, outside Manhattan. Four years after the partnership formed the two doctors noted that their uptown Manhattan office attracted patients from throughout Manhattan, the other boroughs, and even as far away as New Jersey. Recognizing that New York is a city of convenience the pair agreed to expand. "You must be geographically accessible," Dr. Abramow insisted. "We figured, if some people would come uptown, there must be many more who wouldn't, which meant it was time to open an office in midtown."



Dr. Abramow taking notation on an x-ray.

Today Manhattan Podiatry Associates is comprised of four offices: the large main office in Midtown on 54th Street (off Park Avenue) and smaller offices Eastside on 86th Street, Downtown by Wall Street, and Westside on Fifth Avenue. Partners Abramow and Mancuso employ junior partner Mark Landsman, associates Howard Zaiff, Elliott Perel and Ben Dimichino, and a staff of eleven.

Reflecting back on their humble beginnings, the partners contemplate what contributed most to the growth of their practice. They had good street level exposure at their original brownstone but walk-in's were minimal. Initially light advertising in local papers and the yellow pages was probably key. But they quickly developed their referral network by sending letters of consultation to the medical doctor of every patient. Over time the practice's reputation flourished and patient referrals became significant. This can largely be attributed to the practice's keen focus on patient care and its "one stop shop" philosophy. Dr. Mancuso explains, "In 1981 New York City was going through a minimal incision surgery phase. These "closed" surgeons were popular because they performed small incision foot surgeries in an ambulatory office-based setting. We were one of the first in the city to practice traditional "open" orthopedic foot surgery in an ambulatory office based setting. Most of this type of surgery was performed in the hospital."

The two were also pioneers in laser surgery, purchasing a $30,000 carbon dioxide laser in 1982 after only sixteen months in practice. "We bought one because we wanted to be on the cutting edge and to improve patient care," declared Dr. Mancuso. Added Dr. Abramow, "With a laser, we could give them what they wanted - podiatric surgery that got them back on their feet as soon as possible."

Abramow and Mancuso also became very active academically. Mancuso became director of a two year surgical residency program at Medical Arts Center Hospital and Chief of the Podiatry Department. The practice sponsored a preceptorship program, training recent graduates for an additional year. The partners also wrote and published many research papers and lectured frequently. All this developed public awareness and credibility.

This surgically trained duo is bullish on biomechanics, taking pride in incorporating foot function with the medical-surgical aspects of their practice. They firmly believe that most foot problems are rooted in functional pathology and they address each foot problem from a biomechanical viewpoint. Both agree that orthotics are very important as a conservative, non-invasive modality which is preventive and addresses biomechanical/functional faults. If the structural deformity is very significant then surgery is considered.

Dr. John Mancuso demonstrating orthotics from a Northwest Lab display board.

Manhattan Podiatry takes great pride in having consultations and pre/post-op discussions with associates on every surgical case. Every case has multiple opinions. The doctors concentrate on evaluating the biomechanical aspects of each and every foot before surgery so they know the correct surgical procedure. "We don't perform the same procedure on each bunion or every hammertoe. Every foot has unique biomechanical characteristics so the surgical procedure is uniquely geared toward correcting the structural aspects as well as attempting to improve the functional aspects," explains Dr. Mancuso.

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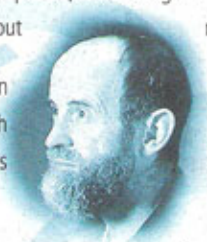
They definitely use orthotics after surgery. In fact, orthotics dispensed are directly proportional to the amount of surgery performed. The post-op foot is studied and, in almost all cases, orthotics are prescribed. "While surgery can reconstruct the structural deformity, orthotics address the biomechanical faults and

*ask*chris

One of the most challenging cases I see is hallux limitus. What do you recommend for this condition?

Hallux limitus is a structural limitation to dorsiflexion at the first metatarsal-phalangeal joint secondary to a severely arthritic joint, a structurally elevated first ray, or the shape of the joint. Passive dorsiflexion of the first metatarsal-phalangeal joint is restricted when the foot is pronated or neutral. This is not to be confused with a functional hallux limitus which is a similar condition that is secondary to the pronated position of the rearfoot and midfoot. In the latter case, passive dorsiflexion of the first MPJ is restricted when the foot is pronated but adequate when the joints of the midfoot and rearfoot are properly aligned.

Hallux limitus, even without any other foot pathology, can be symptomatic because there is insufficient motion at the first MPJ to allow the suprastructure to pass over the implanted foot as the heel rises from the floor. Joint impingement results. Functional orthoses should always be used cautiously in the presence of a true structural hallux limitus because the orthotic will increase the mechanical efficiency of the medial column of the foot and place increased demands for dorsiflexion at the first MPJ. Other coincidental symptoms such as plantar fascitis, metatarsalgia, or foot fatigue may resolve but the patient is left with increased symptoms in the first MPJ or, equally unacceptable, with iatrogenic pain in a previously symptom free joint. Surgical intervention should be considered but may not be an option.



A cutout under the first metatarsal head in conjuntion with a dancer's met pad beneath the 2nd, 3rd, 4th, and 5th metatarsal heads will potentially aggravate the condition if the first ray is structurally elevated or the joint is arthritic.

I have successfully employed a gait plate to promote in-toeing for hallux limitus. With such a device there is a decreased demand for joint motion at the first MPJ but an increased demand for dorsiflexion of the lateral forefoot. Symptoms have resolved but there are several considerations that must be discussed with the patient. Promoting an in-toe gait will create an aesthetic problem that the patient must accept. More importantly, this gait will increase weight bearing of the lateral forefoot and potentially predispose to a tailor's bunion and/or tylomas of the lateral forefoot. Certainly, if the patient is young and active, such a device may precipitate ankle sprains. One must consider which is the lesser of the evils.

Chris Smith, Emeritus Professor of Biomechanics, CCPM—Vice President, NWPL

help to prevent recurrence and restore a more functionally correct balanced foot," says Dr. Abramow.

Each of the doctors has a "favorite" diagnosis for which they like to prescribe orthotics. Dr. Abramow's most positive experience has been with plantar fascitis. Noting the controversial Heel Pain Study undertaken by the American Orthopaedic Foot and Ankle Society, Dr. Abramow is of the opinion that the study was seriously flawed, misleading, and a public disservice. "In my eighteen years of experience, rigid or semi-rigid functional orthotics have allowed me to achieve tremendous success in the treatment of plantar fascitis. In fact, I tell patients they have a 98% chance of resolution of symptoms via conservative treatment."

Dr. Mancuso's most positive results from orthotics are with his favorite diagnosis, functional hallux limitus. He explains, "This condition is usually due to a fully compensating forefoot varus or a long first metatarsal, leading to a functional met primus elevatus. With the metatarsal not structurally elevated but functionally elevated, the hallux cannot dorsiflex. This will lead to a hallux limitus if the metatarsal head is square, or a HAV deformity if the metatarsal head is round. In either case, pain in the joint from either hallux limitus or hallux valgus, without severe arthritis, many doctors would recommend surgery. We would utilize an orthotic device to compensate for the functional elevatus of the first metatarsal by posting 2 - 5 and allow the first metatarsal to drop down therefore allowing unrestricted dorsiflexion of the hallux."

Most practitioners would agree that the greatest percentage of orthotic failures occur when the patient has unrealistic expectations as to the effectiveness of orthotics. "Some patients do not want any invasive treatments. We review the orthotics as a conservative treatment. If the patient expects the orthotic to "fix it" even though the structural component is too far advanced, then this is a failure in the eyes of the patient," note the doctors.

What has contributed to the success of Manhattan Podiatry Associates? The first and most obvious, both doctors agree, is to be well trained, competent and demonstrate consistency of outcomes. They also list communication as key, especially listening to patients expectations. The doctors educate patients about their condition so that they understand their choices and are integral to the decision making process. This is especially important if a patient's expectations need to be brought to a more realistic level. Manhattan Podiatry also shows compassion for every patient, a sincere concern for their well-being. Small details such as shaking each patient's hand are not overlooked.

Drs. Abramow & Mancuso, who themselves have done a commendable job of elevating the profession, view the current competitive environment as a mandate for all podiatrists to work harder and better and to continue to produce consistent outcomes. Only then can podiatrists maintain their market share.

Finally, their advise for new graduates sounds like the formula they followed on their way to success. "Achieve the highest possible level of education, residency training, and professionalism so that you can represent the profession well."

FYI

Heel Stabilizers to be Discontinued

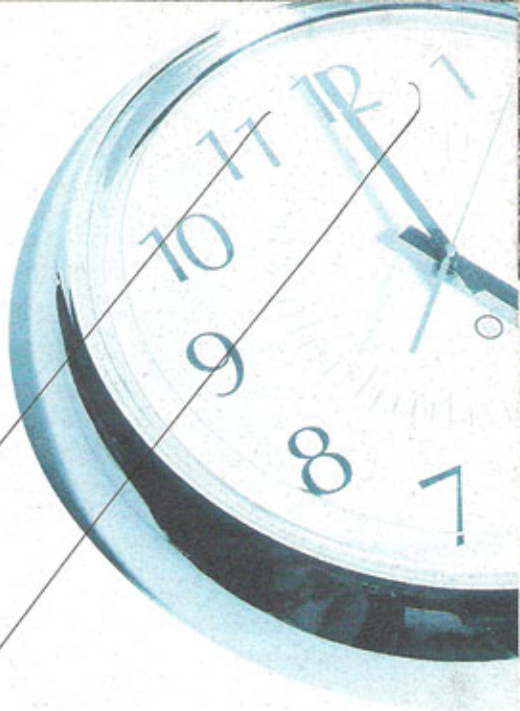
Increasingly stringent standards for workplace safety and disposal of toxic materials has resulted in our decision to stop producing fiberglass heel stabilizers effective January 1, 1998.

Developed by owner Dennis Brown and first introduced in 1965, the rigid heel stabilizers have provided excellent rear foot control for thousands of children, and even some adults. These unique devices are made by alternating the application of layers of fiberglass cloth and a resin compound over corrected casts. Heel posts are made using shredded glass and resin. The volatiles emitted by the resin compound are highly toxic, requiring us to maintain a fire proof room equipped with a sophisticated air evacuation system to assure a safe working environment. Even so, employees must wear face guards and shields with a special breathing apparatus and air quality is periodically inspected by the Department of Labor and Industries. Disposing of waste resin is also an increasingly complicated and expensive proposition regulated by the Disposal of Toxins Program.

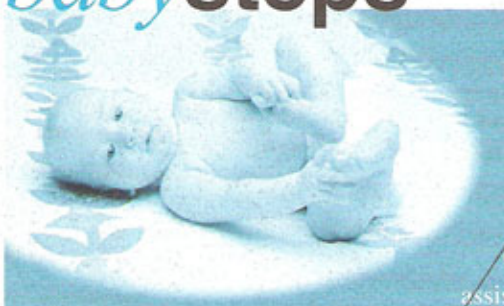
Says owner Dennis Brown, "We are all sad to see the heel stabilizers go, but it's an economic decision. There simply isn't enough demand for heel stabilizers to justify the hazards to our employees and the costs involved in maintaining the workplace and complying with government regulations." Brown is working on developing a heel stabilizer made from the graphite reinforced composites used in our functional orthotics.

When prescribing children's devices after January 1, we recommend normal flex Superglass orthotics with high medial & high lateral flanges and four degree varus rear foot posts to replace Types A, B and C. The same posted Superglass devices with in-toeing gait plates or out-toeing gait plates will substitute for Types D and E, respectively.

All warranty work received after January 1 will be honored with a comparable substitute. We sincerely apologize for any inconvenience this will cause you or your patients.



*baby*steps



Dr. Carl Siciliano and wife Beth of Cordova, Tennessee welcomed a 7 pound 5 ounce baby girl, Caroline Rose, on April 7.

Congratulations to Evelyn Cumbas, an assistant at Dr. Louis Galli's New York City office, on her baby boy, Brandon Luis Soto, born April 23.

We will happily announce your new arrival - call us with the news!

schedule&events

Convention Schedule

Please visit our representatives at these up-coming podiatry conventions:

November 1977 *Hershey Clinical Conference* at the Hershey Lodge & Convention Center, Hershey, PA from November 5 - 7. Visit Booth #67 for the introduction of our PreCustom prefabricated orthotic. In Booth #68 we will cast doctors for complimentary corrective orthotics.

December 1997 *California College of Podiatric Medicine Board Review Course* at the Marriott O'Hare Hotel, Chicago, IL on December 6.

Northwest Podiatric Laboratory, Inc.

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*hours*holidays

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Holidays

Thanksgiving Day
Thursday, November 27

Christmas Day
Thursday, December 25

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