# PODIATRY CANADA

CPMA
Canadian Podiatric Medical Association | L'association médicale podiatrique canadienne

THE LEADING EDGE PUBLICATION FOR PODIATRISTS IN CANADA I SPRING 2014

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**1.** Choi MJ, Maibach HI. Role of ceramides in barrier function of healthy and diseased skin. Am J Clin Dermatol. 2005;6(4):215-223. **2.** Draelos ZD. The effect of ceramide-containing skin care products on eczema resolution duration. Cutis. 2008;81:87-91.

# CPMA president's message

Joseph Stern, DPM • CPMA President

**Traditionally the first quarter of a new year reflects a fresh start and new activities and opportunities. This is also true for the CPMA. We started this year, knowing that we had a lot of work to do.**

The newest thing for the CPMA is getting ready to comply with the Government of Canada's new Not for Profit Act. There is a significant amount of work involved in creating new bylaws, etc., but your CPMA board and bylaw committee has risen to the occasion to ensure that the CPMA will be in compliance well before the stipulated deadline. I would like to thank Brad Sonnema, Richard Bochinski, Jayne Jeneroux, Peter Stavropoulos, David Brooks, Bob Chelin and Mario Turanovic for their input.

More information about the new bylaws is provided on page 11.

In addition to the bylaws, the CPMA is already doing some preliminary work for the 2016 World Congress of Podiatry, which takes place May 26-28, 2016 in Montreal, Quebec. We are fortunate that three key CPMA people -- Dr. Robert Chelin, Dr. Brad Sonnema and Jayne Jeneroux -- were instrumentally involved with the 2013 World Congress that took place in Rome, Italy last October. Their involvement and experience will be valuable as the CPMA plays a lead role with the FIP for the 2016 event.

The CPMA is also gearing up for a spring annual general meeting, which takes place on May 3, 2014 in Banff, Alberta. This year is also an election year for the CPMA executive. The election will be conducted at the AGM.

When I think back to when I was first elected as CPMA President in November 2010, there were a few issues and concerns that I wanted to address, such as increased communication and insurance.

We've made significant progress in both areas and continue to see the benefits of our efforts. We have continued to build on our positive relations with key stakeholders such as the provincial podiatry associations and our CPMA members across Canada, the Canadian Diabetes Association and Special Olympics along with the American Podiatric Medical Association (APMA), the International Federation of Podiatrists/Federation Internationale des Podologues (FIP) and the Society of Chiropodists and Podiatrists (SCP). We have also developed new relationships with other podiatry-related groups, such as the American College of Foot and Ankle Orthopedics and Medicine (ACFAOM), the American Society of Podiatric Surgeons (ASPS), etc.

In regards to insurance, we have met in person or by conference call with all major insurance companies as well as government groups such as the RCMP. As well, we have continued our attendance at the CLHIA conferences and have added attendance at the annual CHCAA conference to our schedule.

While the idea of hosting the world congress in Canada wasn't even on the radar in 2010, it has become a major event that will benefit CPMA members and the podiatric profession across Canada. It will take significant time and effort, but the results will be worth it.

## BOARD CONTACT INFORMATION

**President**: Dr. Joseph STERN – cpmapresident@podiatrycanada.org
**Treasurer**: Dr. Brad SONNEMA – cpmatreasurer@podiatrycanada.org
**Secretary**: Dr. Richard BOCHINSKI – cpmasecretary@podiatrycanada.org
**Past President**: Dr. Mario TURANOVIC – mgtdpm@telusplanet.net
**Executive Director**: Jayne JENEROUX – jjeneroux@xplornet.com

### PROVINCIAL BOARD REPRESENTATIVES:

**British Columbia**: Dr. Howard GREEN – drgreen@drhowardgreen.com
**Alberta**: Dr. Brad SONNEMA – cpmatreasurer@podiatrycanada.org
**Manitoba**: TBA --manitobapodiatry@hotmail.com
**Ontario**: Dr. Bruce RAMSDEN – bramsden@rogers.com
**Quebec**: Dr. Olivier PARENT – olparent@gmail.com

**CPMA -- proud to be the FIP's only Canadian podiatry association member!**

# taking action on a hidden gem

**Most likely, podiatrists in Canada who know about the Canadian Podiatric Educational Foundation (CPEF) have either benefited from its existence, have been part of its administration or both. To many, the (CPEF) is a hidden gem.**

The (CPEF) is a registered non-profit charitable organization that was founded by Vancouver podiatrist Dr. Joe Wong-Sing in 1984. Using his own money, Dr. Wong-Sing established the CPEF to increase awareness about the importance of foot health and also provide education-related funding.

### THE INITIAL GOALS SET OUT FOR THE FOUNDATION WERE

- educate the public how important healthy feet are to daily living
- establish a resource and information centre for the public and practitioners of all health fields
- encourage Canadian students to enter the field of podiatric medicine
- establish a College of Podiatric Medicine in Canada
- provide financial assistance to Canadian podiatric medicine students
- promote establishment of podiatric residency programs in Canada
- provide funds for research in podiatric medicine
- provide post-graduate education for practicing podiatrists

Thirty years later, these goals still remain and most of them have been enacted upon.

The CPEF is funded by donations, contributions and membership dues from the Canadian Podiatric Medical Association (CPMA). Funds are awarded to students based on financial needs rather than academic merit, however, students must meet certain academic standards.

It is a feat in itself that the foundation has been able to help so many podiatry students through financial assistance. However, the ability to help current and future students is now in jeopardy due to many CPEF recipients neglecting to reimburse the CPEF for loans received.

**This is especially disturbing as CPEF applicants are required to sign a form that indicates:**

**a.** I acknowledge that the loan funds approved and negotiated under the CPEF Student's Assistance Program (SAP) must be repaid, in addition to interest based on the prime rate on the first day of the month following the day I cease to be a student based on the schedule of repayment listed.

**b.** If upon default, I acknowledge that the CPEF SAP is entitled to do whatever essential to reclaim the assistance given.

The form also required the signature of a witness who is an official of the loan recipient's educational institution.

At the 2013 CPMA AGM, CPMA members in attendance discussed the importance of continuing the CPEF program and especially seeking repayment from recipients.

Dr. Doug Lamb, a podiatrist in Victoria, B.C., has volunteered to take on the task of seeking repayment from recipients of the CPEF SAP. CPMA members with outstanding loans are encouraged to contact Dr. Lamb at jbdpm@shaw.ca

With everyone working together and paying back any monies owing, the CPEF can continue to help future students and thereby advance the podiatry profession in Canada.

*Photo courtesy of the Fairmont Banff Springs Hotel*

# International Region 7 Annual Conference
# May 2-4, 2014

*The Fairmont Banff Springs Hotel - Banff, Alberta*

## PROGRAM

*please visit our website for the detailed program*
http://www.region7apma.org/annual_meeting_schedule2014.pdf

*Speakers include*

Dr. Matt Garoufalis
Dr. Marie-France Guimond
Dr. Francois Harton
Dr. Brent Haverstock
Dr. Michael McGlamry
Dr. Eureka Nakai
Dr. Laurie Parsons
Dr. Kerry Sweet
Dr. Ken Unger

*Topics include*

1st MPJ Arthrodesis
Biomechanics
Current Treatments for Diabetic Foot Ulcers
Fibular Periosteal Flap in Lateral Ankle Stabilization
Fireside chat - case discussions
Management of Plantar Fasciitis -
What the Evidence Tells Us
New Therapeutic Advancements in the
Treatment of Onychomycosis

**ONLINE DELEGATE REGISTRATION AVAILABLE**

http://region7apma.org/annual_meeting_reg_doctors.html

Cost:
Region 7 Members: $199.00
Non-Region 7 APMA Members: $349.00
Non-APMA Member: $825.00

The delegate registration fee includes general sessions, course syllabus, continental breakfasts, one lunch, refreshment breaks & reception.

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**SPONSORSHIP & EXHIBITION OPPORTUNITIES AVAILABLE**

Please visit our website at
http://www.region7apma.org/annualmeeting.html
for information. Alternatively, you may contact the Region 7 office at 780.922.7609 or email jjeneroux@xplornet.com

We look forward to your partnership in making our conference a success!

*Photo courtesy of the Fairmont Banff Springs Hotel*

**VENUE & ACCOMMODATION**

The Fairmont Banff Springs Hotel
405 Spray Avenue
Banff, Alberta

Please contact the hotel directly and quote the "Region 7 Conference" to make a reservation and receive the conference room rate.

Our room block will be released on Tuesday, April 1, 2014.

Reservations Department: 403.762.6866
Global Reservations Centre: 1.800.441.1414
Online Reservations:
https://resweb.passkey.com/go/cpparegionvii

Nightly room rates starting at $199.00
(+ $10.00 Service Charge per person + taxes)

International Region 7 Association
T. 780.922.7609
jjeneroux@xplornet.com | region7apma.org


**One of the best aspects of an Executive Director's position is the variety inherent in the job and the opportunity to deal with numerous people on a diverse range of issues.**

Every time the phone rings, you never know what the issue will be. Often it's an insurance company wanting confirmation of CPMA membership or a person wanting more information about the podiatry profession. Other times it is a potential student calling, either to obtain specific information about podiatry or a term paper or exam questions they are working on. Often, it is the general public calling, asking questions about podiatrists, etc. We also get calls from podiatrists from other countries wanting to know if they are able to practice in Canada.

Lately, a lot of work has been focused on dealing with the requirements of the federal government's Not for Profit Act. A key priority was drafting new bylaws, which was accomplished through the bylaw committee. Spring also signals preparations for the APMA House of Delegates, working on the spring issue of the CPMA magazine and, this year, organizing the 2014 CPMA AGM.

The CPMA is a dynamic organization involved in a broad variety of issues and activities. The Board is comprised of representatives from each member province and it is through these representatives that we are often informed about issues and activities at the provincial level. But we are also fortunate to hear from individual members too, which enables the CPMA to reach out further. A case in point is the upcoming Primary Care Today (PCT) conference that is taking place May 8-10, 2014 at the International Centre in Toronto, Ontario. We looked into attending this conference a couple of years ago, but the decision at the time was to not attend. Instead, we focused on attendance at insurance-related conferences and meetings. Recently, two members from the OPMA reached out to the CPMA about attendance at the PCT this year. Through discussion with the CPMA executive, agreement was given and a booth was secured right away. Thank you to Dr. Irv Luftig and Dr. Robert Chelin for alerting the CPMA about this year's conference and thank you also to Dr. Luftig and Dr. Bruce Ramsden for arranging booth representation.

As both Dr. Stern and I have often said, communication is an important component of the CPMA, and we strongly encourage two-way communication with CPMA members.

If you have issues, questions or ideas, please share them with the CPMA. Contact information is listed on page 3.

Jayne Jeneroux
Executive Director
Canadian Podiatric Medical Association

Save the date

# Montreal, Quebec

## 2016 World Congress of Podiatry

May 26–28, 2016

# new age orthopaedic shoes. the stretchable upper option!

**So many medical referrals to the shoe shop come requesting a roomy toe-box and seamless upper to accommodate any variety of forefoot pathologies. Traditional extra-depth leather orthopedic shoes with non-shearing Plastazote linings, like Apex Ambulator, can be useful for sure. But they carry with them a number of annoying liabilities including the added weight and bulk. This inevitably leads the patient to say..... 'I won't wear them, they're ugly!'.**

In reaction, some traditional orthopaedic shoe lines are expanding to meet the needs and wants of a younger-minded aging population. Heavy leather extra depth toe boxes sits alongside a variety of attractive, accommodative stretch material shoe options.

**Propet and Orthofootwear** use Lycra and nylon in an "accordion-like expandable pattern to help create lightweight super stretch toe boxes able to comfortably accommodate some of the most challenging arthritic feet.

Hammertoes, bunions and mallet toes can sit comfortably against the toebox material with limited risk of abrasion.This is particularly important with the diabetic foot!

**Xsensible** models are pricey but are also more fashionable with craftsman like quality. Xsensible created a complex multilevel material made from Lycra and spandex that is laminated to a razor-thin outer layer of leather. The result is the ultimate in "stretch leather" seamless footwear. (notice below the illustrated stretch in the full elastic toe box for a hammer toe).

**Pedors** markets some more affordable orthopaedic options with thick stretch fabrics. Unfortunately they can prove to be less than attractive. That being said, their wider outsole platforms, deeper uppers, accommodative Velcro closures and extensive width options make them a prime choice for that challenging post-operative and/ or ademitous foot.

**Portofino** dabbles in the stretch category but the fabric has minimal elasticity. Their gussets are well placed and the shoes are very fashionable and attractive to numerous age groups.

Running shoe designers are also now using accommodative stretch fabrics in some of their high-end road shoes. Asics, for instance, uses what they call their "biomorphic" gussets to better accommodate a nasty hallux valgus or bothersome Taylor's bunion. (Stability model Gel Kayano as well as the neutral Gel Nimbus).

But with all the forefoot accommodation that comes with the new stretch toe box models, I find it curious that the designers usually miss incorporating a stiff rockered sole in models clearly aimed at patients with forefoot pathologies.

Shoe prescriptions/recommendations for the arthritic, diabetic and / or traumatic foot often read:
"Please fit patient with shoe that has
1) accommodative roomy toe box
2) seamless upper
3) stiff rockered sole"
And unfortunately 'two outta three' IS bad.

A stiff rockered sole helps to offload the forefoot and is a key element in managing this type of ambulatory foot.

Lightweight accommodative stretch options with inspiring cosmetics are indeed welcomed, but new age designers need to incorporate some old school stiffness and support with the elastic so that those forefoot issues are not only accommodated but are protected against flex-related stress while walking or running.
For a review of some stretch upper options, visit Ladysport.ca and look for a listing of key stretch models or browse The Shoe Update for more information.

*Phil Moore BA-BPHE Queens University*
*Co-Owner Ladysport and FitFirst*
*Vancouver*

# don't fall victim to fraud!

Dear Customer

For many small business owners, fraud poses serious security threats. Businesses of all sizes are vulnerable to internal and external fraudulent activities, which ultimately cost Canadians billions of dollars each year. As a small business owner your reputation, your corporate data and your finances are easy targets for scammers and unscrupulous employees. Small businesses are especially vulnerable as they have fewer resources to detect and prevent fraud.

Here are some examples of common types of fraud:

Internal Fraud : Employee theft, billing schemes
External Fraud : Impersonators, identity theft, cyber fraud, unsolicited advertising invoices
Cyber Fraud: An increasing concern for local businesses

In this world fueled by technology, scammers use everything from emails to software to steal critical information from you – passwords, bank information, client lists, etc. This can lead to serious problems and even jeopardize the future of your business. Ultimately, as a small business owner, you shouldn't underestimate the potential risks and high costs of falling victim to cyber fraud.

Be aware of fraud and take action: View tips on how to recognize fraud and protect your business.

## DETECTING FRAUD

For more information about detecting fraud, visit www.yellowpages360solution.ca/resources/fraud

http://www.yellowpages360solution.ca/wp-content/uploads/2013/05/YPGFraudGuide_vfinal.pdf

## WHO TO CONTACT WHEN YOU SUSPECT FRAUD

Competition Bureau of Canada
1-800-348-5358
www.competitionbureau.gc.ca

Yellow Pages Group
1-877-909-9356

Canadian Anti-Fraud Centre
1-888-495-8501
www.antifraudcentre.ca

Better Business Bureau
http://www.bbb.org/canada/

# don't fall victim to fraud! cont'd.

**Fighting Fraud in Small Businesses**

Small businesses often have limited resources for fraud prevention programs. Yet, they are among the biggest targets for fraudulent activities with revenue losses related to employee-perpetrated fraud estimated at $3.2 billion per year according to Canadian accounting associations.

**To avoid falling victim to fraudulent activities, small businesses should take steps to identify and prevent risks for fraud within their organizations.**

**9 Steps to Preventing Internal Fraud**

Internal fraud is perpetrated from within the business by its employees. Unfortunately, this constitutes the most common type of fraud. Use the following tips to help develop a fraud prevention program for your business.

**Know your fraud risks:** Determine where your company's specific vulnerabilities lie in order to create and implement internal prevention controls.

**Employee background checks:** Check references, employment and educational history to ensure there's no previous history of fraud or illegal activity. If you're filling a position managing the company's assets, you may want to consider conducting a credit check with the authorization of the candidate.

**Ensure monitoring of cash situations** and create system of checks and balances: Have security cameras installed to monitor activity at registers and in inventory storage areas. Fraud is less likely if people know they're being watched. Expenditures should always have a multi-step approval process consisting of a manager and an accountant to ensure validity of expense and to run the math. Additionally, key business functions should never be handled by a single employee, this makes fraud easier to conduct and to cover up.

**Conduct surprise audits:** If you do not have internal auditors, have your accountants periodically visit and audit specific functions of your business where fraud might occur. These audits are less designed to discover fraud and more to act as a deterrent as employees will know it will be more likely to be uncovered.

**Control the banking:** Small business owners should check bank statements themselves to avoid cheque tampering. Watch for missing cheques, cheques issued out of sequence, unknown payees, cheques which look altered, cheques not signed by authorized signatories, or any other unusual items. Conduct bank reconciliations once a month and consider using online banking tools if you regularly have many transactions and large dollar volumes.

Use only approved vendors: This can help fight billing schemes and phony invoices. A list of management-approved vendors should be available to all staff and this list should be routinely checked against invoices. Look for unknown vendors, vendor names similar to approved vendor names, vendors with no physical address or phone number or vendors with addresses matching an employee's address.

**Create and communicate your company's fraud policy:** Make all employees aware of what activities constitute fraud, the tools being used to combat it and the company's zero tolerance policy on fraud. Ensure employees know what to do and who to contact if they suspect fraud and be sure to inform employees about the actions the company will take if it is determined fraud has been committed. Often the communications themselves become a deterrent to fraudulent activities.

**Employee Assistance Programs:** Often internal fraud is committed by employees undergoing dire hardships and feel they have no other alternatives. An employee assistance program can help mitigate this risk and if a formal program is too expensive, institute an open door policy where employees feel they can approach management for help when it is needed.

**Take action when fraud is discovered:** Obviously the punishment should match the offense but having a fraud policy is useless if you are unwilling to enforce it. Once small frauds are overlooked or permitted without repercussions, larger ones become possible. Consider options such as suspensions, demotions, salary cuts, probation, dismissal and legal action for differing levels of violations.

**Preventing Common Types of External Fraud**

There are a number of scams targeting small businesses that range from strange office supply orders to bills for advertising that was never ordered. Often careful attention and verification can prevent businesses from falling victim to this type of fraud.

**Domain name renewal:** Small businesses with their own websites can be confused or caught by unsolicited letters warning them that their Internet domain name is expiring and must be renewed. Sometimes these letters offer them a new domain name similar to their current one. If you have a registered domain name, be sure to carefully check any renewal notices or invoices you receive.

**Check that the renewal notice** matches your existing domain name. Watch for small difference like ".org" instead of ".ca" or missing letters in the web address.

**Check that the notice** comes from the same company with whom you registered the domain name.

**Check your records** for the expiry date of your existing domain name and see if this matches the notice.

**Business directory listing or other unauthorized advertising:** This type of fraud may be disguised as a solicitation for an update of an existing advertising product you have purchased or as an offer for a free listing when it is actually an order for a listing requiring payment at a later date. Other times, the communication may be in the guise of an order form originating from well-known advertising suppliers when it actually isn't. Often, if the offer seems too good to be true, it usually is. Consult our guide on Yellow Pages directory fraud for specific elements to watch for related to fraudulent solicitation around Yellow Pages Group products.

**Office supplies:** Small businesses may receive invoices for goods they never ordered. Often this will revolve around items you may order regularly such as paper, printing or maintenance supplies. Be sure to keep records of all orders placed and check these against all invoices received. In other instances of this type of fraudulent activity, businesses may receive phone calls which falsely claim to be from their "regular supplier" with a limited time or special offer. These calls often wish to confirm your address or an existing order. Supplies offered in these calls will be overpriced and of bad quality. Always deal directly with your supplier contact or insist that you will call the caller back, at which point you can dial your regular supplier to confirm this offer is indeed from them.

**Equip your front lines:** Make sure your staff processing invoices or answering phone calls is aware of these types of fraud as they will often be the main points of contact. Always check that goods or services were ordered and delivered before paying an invoice.

**Be careful about your business information:** Never give out information about your business for advertising purposes unless you know how the information will be used and you can confirm you are dealing with your standard advertising supplier.

**Get it in writing:** Never accept a business proposal over the phone. Always request the offer in writing and limit the number of people in your company who have the authority to approve purchases or create a multi-level approval process.

# cpma bylaw revisions initiated by federal government changes

**The new Canada Not-for-profit Corporations Act (NFP Act) establishes a new set of rules for federally incorporated not-for-profit corporations in Canada. These new rules replace Part II of the Canada Corporations Act (the old Act), the law that has government federal corporations for nearly a century. The rules under the NFP Act are more modern, flexible and more suited to the needs of the not-for-profit sector.**

### THE BENEFITS OF THE NFP ACT INCLUDE:

- a clear set of rules that govern the internal affairs of federal not-for-profit corporations
- less red tape with simplified processes
- more flexibility to make fundamental changes, such as amalgamations, that were not permitted under the old Act
- a more objective standard for directors in carrying out their duties and responsibilities that will reassure individuals who decide to be on a board of directors.

### DO THE NEW RULES APPLY IMMEDIATELY?

The NFP Act does not automatically apply to existing corporations. Rather, every existing federally incorporated not-for-profit corporation will have to take action to make the transition to the NFP Act. Until that transition is made, the rules under the old Act still apply.

### WHAT IS THE TRANSITION PROCESS?

The CPMA needs to replace any letters patent and bylaws with new charter documents by submitting articles of continuance to obtain a Certificate of Continuance and creating and filing new bylaws. The articles and bylaws must comply with the NFP Act. These charter documents set out the primary rules governing the CPMA.

### WHAT IS THE DEADLINE FOR MAKING THE TRANSITION AND WHAT HAPPENS IF A CORPORATION DOESN'T MAKE THE TRANSITION?

All not-for-profit corporations must make the transition by October 17, 2014. Corporations that do not make the transition by the deadline will be assumed to be inactive and will be dissolved.

### WHERE IS THE CPMA AT IN THE PROCESS?

The CPMA is well-positioned to make the transition to the NFP Act by the October 17, 2014 deadline.

A small sub-committee of CPMA members have drafted new bylaws to comply with the new act and will be sharing these with CPMA members for review and comment. The new bylaws will be discussed and voted on at the upcoming CPMA AGM, which takes place May 3, 2014 at the Fairmont Banff Springs Hotel, in Banff, Alberta.

# secrets of success: is your front desk functioning at 100%

*by: Lynn Homisak, SOS Healthcare & Management Solutions, LLC - www.soshms.com*

Consider your front desk the welcome wagon of your practice. You may spend thousands of dollars to boost marketing. You could have the best new technological widgets and gadgets podiatry has to offer. You might even have a bedside reputation like that of Grey's Anatomy's Dr. McDreamy and yet, first time patients would never even know. What if something simple stood in the way of a new patient ever meeting you? Losing these patients could easily be the result of a poorly functioning front desk. What you don't know, can hurt you. Getting your front desk functioning at 100% involves having certain systems in place. Here's Part I of a two part article to get you started.

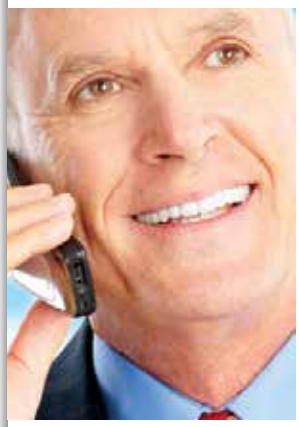
**Phones:** How are your phones being answered? Quick and cold ["Hold please!"] or attentive and caring? "Good morning, Dr. ___'s office, Dawn speaking. How can I help you?" Does the caller get an initial feel good moment? [It only takes 4 seconds to form that first impression.] Do they get that they are speaking to a qualified professional? Are they satisfied; getting questions answered promptly and accurately? Does the dialog convince the caller that seeing the doctor and making an appointment is the best medicine or are they compelled to hang up and call elsewhere? Does your staff have prepared scripts to help guide conversation, assure appropriate response, or are they giving off the cuff, anecdotal and more importantly, unauthorized medical advice? You should know.

**Scheduling:** Regardless of what EMR system used, digital schedules can be programmed to align a correct amount of time to each individual procedure or code. Yet, more often than not, offices insist on utilizing the "old standby" 10/20 minute blocks…for everything. Proper scheduling includes understanding the difference between a complicated vs. a routine vs. a follow up visit; knowing what questions to ask to appropriately triage calls; when it's feasible to double book patients [and when not to]; and understanding [with the doctor's input] how much time each
procedure takes in order to effectively manage the schedule. Inexperienced, random scheduling leads to patient flow issues, frustrated staff, rushed physicians and disgruntled patients. If discussion about better scheduling strategies is not on the staff meeting agenda to discuss making necessary amendments, it should be.

**Wrong staff positioning:** It is essential to make sure that all front desk personnel demonstrate an acceptable level of control, but are not controlling; polite, not demanding; friendly, but not needing to be friends with every patient, and knowledgeable, but not a know-it-all. Sounds simple enough and yet, if I only had a nickel for every misplaced staff person [whose shortcomings could not justify them sitting in that "hot" seat] and another nickel for the excuses that keep them there... well, I would be writing my articles from the coast of some exotic location. When I interview a receptionist who admits they've been trained and would rather be working in a clinical setting – bells and whistles go off. Put people where their strengths are and they will be more productive.

**Inconsistent, unwritten or unenforced policies:** Written policies are a critical part of every practice; without them, there is chaos and confusion. Policies [or rules] set protocol. They assure that all activities are conducted in a similar manner and put everyone on the same page. Some of the essential front desk include requirements for staff handling money; patient financial responsibilities, copay collections, dealing with missed, cancelled and late appointments as well as walk-ins, no shows and emergency; physician-referred patients; and missing insurance referrals – just to name a few. Remember, a written policy without discussion, training and enforcement is only a static piece of paper.

To make policies meaningful, there must also be consequence for non-compliance and they should be carried out not just "some of the time" – consistently, across the board. Someone needs to be in control of that front desk. If you [or your staff] aren't, the patient is.



**Tools for success:** Operational systems that we sometimes take for granted at the front desk must be immediate and rooted, or quickly at their fingertips, not down at the end of the hallway, or "Can I get back to you with that?" Those systems include procedure "how to" and policy manuals, clear cut job delineations, website appointment scheduling, access to online insurance websites, automated appointment reminders, scanner, shredder, online or onsite fax, updated computer software, digital card readers, credit card machines, hands-free headsets and ergonomically-correct seating. Having easy access to equipment and keeping it in working order sets staff [and the practice] up for success, not failure.

For each difficulty presented, there is a solution…and before you can fix them, you must identify them. Check back because in our next article, we will address additional factors of contributing front desk inefficiencies, e.g. inadequate training, front office/back office communication gaps, collections, lack of attention to detail [data input errors] and indifferent customer service.

*Ms. Homisak, President of SOS Healthcare Management Solutions, has a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management's Lifetime Achievement Award and recently inducted into the PM Hall of Fame. Lynn is also an Editorial Advisor for Podiatry Management Magazine and recognized nationwide as a speaker, writer and expert in staff and human resource management.*

# provincial updates

## British Columbia

The BCPMA introduced our new and improved interactive website in January. This site highlights a "Find a Podiatrist' section, member benefits, and we will be adding a member's blog, classified section and library section shortly. Please visit www.bcpodiatrists.ca

- The Board of Directors held a Board retreat in November to discuss the future direction of the BCPMA, review our goals and mission statement.

- The BCPMA was awarded the Canadian Diabetes Association's 2013 Outstanding Regional Partnership Award. We were very proud to receive this recognition. The award was received by Dr. Joseph Stern, on behalf of the BCPMA at the November 2103 Live Well With Diabetes Seminar.

- Members of the BCPMA assisted with the Shoe Renu program in December. This program provides foot care for the homeless and disadvantaged as well as provided shoes. Shoes were collected at podiatrists offices then refurbished and distributed to individuals in need.

- The BCPMA exhibited at the recent Vancouver Wellness Show in February. This event has over 20,000 public attendees and our booth attracted much attention.

- Dr. Green will be presenting a workshop at the Talk Seminar at Kwantlen College at the end of March. This is an educational seminar provided to seniors.

- BCPMA will be holding its annual scientific seminar on June 13 & 14, 2014 at the River Rock Hotel Resort Casino. A CPR course and Golf Tournament will be held in conjunction with the conference. We expect this to be a marquee event. Go to our new web site for registration & hotel information.

- BCPMA will be attending and providing volunteers for the Special Olympics National Games on July 9-12, 2014.

Howard Green, DPM
President, BCPMA

## Alberta

One of the primary focuses of the College of Podiatric Physicians of Alberta is the continued development of the College. A fee negotiation committee has been established and their first planning meeting was held January 10, 2014.

The CPPA executive will be conducting a strategic planning session in the near future. In the meantime, the CPPA is hosting the 2014 Region 7 conference, which will take place May 2-4, 2014 at the Fairmont Banff Springs.

The Fairmont Banff Springs will also be the location of the 2014 CPPA Annual General Meeting as well as the 2014 CPMA Annual General Meeting.

Dr. Brad Sonnema
President
College of Podiatric Physicians of Alberta

# provincial updates cont'd.

## Manitoba

We say goodbye to a few members on our executive committee. Dr. Alicia Snider is stepping down from being the Manitoba Podiatry Association President along with Dr. Pamela Monk and Dr. Rob Bellmont. We thank them for all their hard work and dedication to furthering podiatry in Manitoba. We now welcome Dr. Gillian Aldous as President, Dr. Tejel Patel and Dr. Fiona O'Hara as our new executive members. The executive has planned to host more continuing education workshops this year for our members.

As an association we held a shoe drive this winter and collected new and gently used footwear, new insoles and socks for Siloam Mission, a charity and shelter helping Winnipeg's homeless. Two of our members volunteer their time, skills and services at the Siloam Mission medical clinic attached to the shelter.

Manitoba Podiatry Association (MPA) members were present at a health expo week at Costco in the fall. Members answered customer's foot concerns, gave footwear advice and promoted the podiatry profession in Winnipeg. It was a fun day and the MPA hopes there will be further opportunities to promote the profession in the future.

We are looking forward to 2014 with anticipation.

Manitoba Podiatry Association
manitobapodiatry@hotmail.com
www.mbpodiatry.ca

## Ontario

The political situation in Ontario is very fluid and that fluidity impacts on many of the initiatives in which the OPMA is interested or engaged. There is at least a moderate likelihood that the Liberal government will be forced into a Spring election over the budget. The New Democratic Party (NDP) holds the balance of power in the Legislature and may be sufficiently emboldened by its performance in the last two rounds of by-elections to bring down the government.

The review of the chiropody and podiatry professions by the Health Professions Regulatory Advisory Council (HPRAC) began on January 1st. The College presented its case to HPRAC for conversion to a podiatry model on February 13. HPRAC aims to complete its review with recommendations to the Minister by September, 2014. HPRAC is only advisory and it will be up to the Minister of Health and Long-Term Care to decide what happens with HPRAC's recommendations.

The Ontario Budget for Fiscal Year 2014-15 is expected to be announced in late March. Podiatry is the only profession that hasn't experienced OHIP changes. The Ministry is looking at the rationalization of all professions' public funding. It is therefore possible, although not expected, the OHIP coverage for podiatrists may continue for persons up to 19 years of age and over 65 and for persons on social assistance programs, but may be withdrawn for persons between 19 and 55. This would reflect the reform of public funding for physiotherapy and optometry. [Chiropractic was delisted from OHIP in 2004; physiotherapy was transferred from OHIP to alternate funding models last year; since 2004 optometry is still covered by OHIP, but only for persons up to 19 and over 55 and for those on social assistance programs.] The OPMA continues to work with EHB insurers and brokers to correct confusion and to remove obstacles to co-payment with OHIP of podiatrists' billings.

The review of the Healing Arts Radiation Protection Act (HARPA) by the Ministry appears to be at least temporarily becalmed. Nonetheless, some colleges and professional associations continue to collaborate on the development of directions and ideas to present to the Ministry and continue to urge the Ministry to proceed with the review.

Bruce Ramsden, DPM

# Québec

With one of the coldest winters in the history of the province of Quebec, we are trying not to hibernate until April!

As the president of the Quebec Podiatrists Association, I will be present at the CPMA AGM in Banff on May 3, 2014.

Quebec wants to work with the CPMA on various projects, including the 2016 FIP World Congress of Podiatry and insurance coverage. The Ordre is having elections now and we will meet the new administration at the beginning of April. And very soon, 25 new podiatrists will graduate from the UQTR in May.

I'm sorry, but for now, my hands are frozen. I will update more in the next edition!

Dr. Olivier Parent
President
Quebec Podiatrists Association

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# URISEC® CREAM & LOTION

**THERAPEUTIC PREPARATIONS FOR DRY SKIN CONDITIONS**

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Moisturizing therapeutic hand & body treatment cream for dry skin conditions. Leaves skin smooth, soft and supple.

**Contents:** Urea 10% USP in an emollient cream base. Non-greasy, soothing formula.

**Supplied:** 75 g & 120 g tubes


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URISEC® 40
ÉMOLLIENT TISSULAIRE

**A powerful formulation for hard and rough skin and damaged or diseased nails.**

## ALSO AVAILABLE


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Potent keratolytic tissue softener for dry skin conditions and damaged or diseased nails.

**Contents:** Urea 40% in an emollient cream base.

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ODN1203307

# clinically speaking: what is the impact of non-steroidal anti-inflamatories nsaid's on bone healing

By Anthony C Yung, DPM FACFAS

Nonsteroidal anti-inflammatories are one of the most frequently prescribed medications for the treatment of musculo-skeletal injuries. They often play a key role in managing pain following injury. Their effects on addressing pain and reducing inflammation are well established. However their role in the healing of skeletal injuries has come under scrutiny. A number of studies have questioned their role in the healing of bone from osseous injuries or surgery. This has led to varying opinions on their suitable role in musculoskeletal injuries. Do NSAID's inhibit fracture, tendon or ligament healing? What dosages or for how long can they be used safely? It is worth a look at reviewing what is known to date.

NSAID's achieve their action by inhibiting Cylcooxygenase (COX) in the arachidonic acid pathway to reduce prostaglandins, prostacyclin and leukotrienes. It is thought that the COX-1 is involved in expression of cellular mediators present in physiologic processes such as gastric mucus production, platelet aggregation, renal blood flow and neovascularization. The COX-2 pathway directs pro-inflammatory cytokines and prostaglandin production thereby reducing pain, inflammation, elevation of body temperature and inflammatory cells.

Bone healing progresses in a serious of events including hematoma formation the development of granulation tissue, neovascularization, callus formation, bone deposition and remodeling. Local release of prostaglandins occurs following a fracture as a result of the inflammatory response. The Cox-2 pathway is thought to be an important part of the endochondral and mesenchymal healing pathway.

Animal models have shown that prostaglandins play an important role in bone formation. Prostaglandins play a role in either a stimulatory or resorption role of bone by stimulating osteoblasts and osteoclast production or suppressing osteoclast function (*Kawaguch et al.*).

The exact mechanism of involvement is unknown but proposed pathways that Cox-2 suppression may affect bone healing include: impairment of osteoblast production and function, impairment of callus or fracture site angiogenesis, and interfering with chondrocyte differentiation.

Cellular models reinforce the notion that NSAIDs clearly play a role in bone formation. Prostaglandin administration has shown an increase in bone mass formation (*Zhang et al.*). In gene knock out experiments with mice those with impaired COX-2 genes demonstrated impairment of bone healing whereas COX-1 knockouts did not.

Rat studies bone healing have shown varying effects NSAID's from no effect to significant delays in time and bone quality. One study of ketoprofen and celcoxib showed no difference over a 3 week period while others using ibuprofen, celexoxib, indomethacin demonstrated changes with greater changes with administration longer that 3 weeks.

Short durations of NSAID's and Cox-2 inhibitors use for as little as 7 days have demonstrated healing impairment but usage for less than 7 days seems to have no effect on bone healing. The degree to which NSAID's affect healing varies with the drug and

(cont'd)

## What is the impact of non-steroidal antiinflamatories NSAID's on Bone Healing (cont'd)

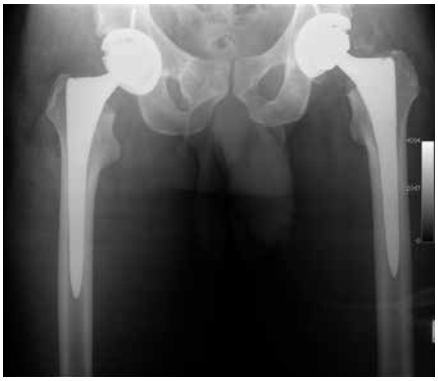
dosage used. There are differences in impact on the type and severity of boney repair. The evidence shows a clearer impact on endochondral (non-rigid) repair than intramembranous (rigid fixation) repair.

Animal modeling demonstrates a clear impact of NSAID's on bone healing that is drug, dose and species dependent. Duration of therapy longer than 3 weeks is much more impactful but effects have been seen with as short as 7 days of administration. Acetaminophen did not seem to have any effect on bone healing. The evidence in rat models is stronger than in dog models that more closely mimic human physiology and this

is where things get a little murky. The translation of what is seen on a cellular level hasn't been strongly reproduced in human studies. The human studies on this subject are far from comprehensive. The studies are primarily retrospective or case studies and the data is mixed.

Some retrospective studies specifically looking at NSAID use and bone healing demonstrate no effect on union rates while others do. Bhattacharyya et al. performed a retrospective analysis of 10000 patients and concluded that NSAID use within the first 3 months had a 400% increase in nonunion. Giannoudis in a study of femoral shaft fractures in which patients used diclofenac or ibuprofen for 21 weeks associated their used with non-union and delayed fractures. Some studies show no effect of NSAID's on spinal fusion rates whereas some associate NSAID useage for greater than 3 months with lower fusion rates. A meta-analysis of observational studies by Dodwell concluded that NSAID's do not increase the risk of fracture nonunion.

The most compelling evidence focuses on the study of heterotopic ossification following hip joint replacement. Fransen performed a Cochrane analysis of 17 trials demonstrates that NSAID use can reduce heterotopic ossification by 59%. However the cascade for heterotopic formation differs from bone healing and caution should be used in translating these effects to normal bone healing. High quality studies are needed to provide greater direction.



There is no robust evidence on the role of NSAID's and bone healing in humans. In the absence of proven safety many have concluded that there is enough evidence to suggest that NSAID's should be considered a risk factor for delayed and non-healing bone injuries. This is not on the order of diabetes, smoking or steroids but a minor risk for impairment of bone healing. Specific recommendations as to the role NSAID's should play in therapy for bone injuries are varied and based upon opinion not hard science. These vary from absolute contraindication to an acceptance for shorter periods of time such as not more than 7 days. There is however consensus that there is enough evidence to avoid long term use of NSAID's for bone injuries and to avoid its use in high risk patients.


Bergenstock et al. A comparison between the effects of acetaminophen and celecoxib on bone fracture healing in rats. *J Orthop Trauma 2005: 717-723.*

Dodwell et al. NSAID exposure and risk of nonunion:a meta-analysis of case-control and cohort studies. *Calcif Tissue Int. 2010;193-202.*

Fransen and Neal. Non-steroidal anti-inflammatory drugs for preventing heterotopic bone formation after hip arthroplasty. *Cochrane Database of Systemic Reviews. 2004. No.3*

Giannoudis et al Nonunion of femoral diaphysis:the influence of reaming and non-steroidal anti-inflammatory drugs *J Bone Join Surg 2000;655-658.*

Kawaguch et al. The role of prostaglandins in the regulation of bone metabolism. *Clin Orthop Relat Res. 1995;313-36-46*

Pradhan et al. Ketorolac and spinal fusion: does the perioperative use of ketorolac really inhibit spinal fusion?" *Spine 2008: 2079-2082.*

Zhang et al. Cylooxygenase-2 regulates mesenchymal cell differentiation into osteoblast lineage and is critically involved in bone repair. *J. Clinical Investigation 2002; 1405-1415*

## Annual Scientific Conference 2014: *Friday, June 13 & Saturday, June 14*

*River Rock Casino Resort - Richmond, BC*

**Speakers Confirmed to date…**

Mr. Nigel Trevethan
Dr. Jack Taunton
Dr. Kam Shojani
Dr. Doug Ritchie, Jr.
Dr. Byron Hutchinson
Ms. Lynn Homisak
Dr. Pankaj Dhawan
Dr. Keith Baxter
Dr. Dana Alumbaugh

**Online Delegate Registration Available…**

https://www.bcpodiatrists.ca/annual-conference/online-registration

Cost:
BCPMA Member: $395.00
CPMA/Region 7 Member: $495.00
Non Member: $795.00

*CPR Course: $150.00*
*Thursday, June 12, 2014 - 6:00 - 9:00 pm*

**Venue & Accommodation…**

River Rock Casino Resort
8811 River Road | Richmond, BC

Please contact the Resort directly & quote the "**BCPMA room block**" to make a reservation & receive the conference room rate of $139.00 plus applicable taxes (Standard Room).

Our room block will be released on **May 23, 2014**

T: 604.247.8900 Toll free: 1.866.748.3718
F: 604.207.2641 reservations@riverrock.com

**Sponsorship & Exhibition Opportunities Available…** *Please visit our website at*

http://www.bcpodiatrists.ca/annual-conference/sponsorship-exhibition

*Exhibitors Confirmed to date*

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| Canadian In Home Care | Dormer |
| New Balance - National | New Balance - Vancouver |
| Paris Orthotics | Paragon Orthotics |

British Columbia Podiatric Medical Association

*Photo courtesy of the River Rock Casino Resort*

BCPMA Office
T: 604.985.3338
info@bcpodiatrists.ca
bcpodiatrists.ca

# Plan To Attend the 2014 CPMA Annual General Meeting

**WHEN:** May 2, 2014 – 12:30 - 2:00 p.m.

**WERE:** Fairmont Banff Springs Hotel

**WHAT:** the Annual General Meeting of the Canadian Podiatric Medical Association

**WHY:** Be part of the discussion of your national member association.

*** NOTE:** This is also an election year, and elections for the positions of President, Secretary and Treasurer will be held at the AGM.

# CPMA Seal of Approval/Acceptance Program

The Canadian Podiatric Medical Association's Seal of Approval/ Acceptance Program recognizes products that are beneficial to foot health. The CPMA program has two components:

**Seal of Acceptance**
The Seal of Acceptance evaluates footwear, materials, insoles, hosiery and equipment.

**Seal of Approval**
The Seal of Approval evaluate therapeutic products and their adjuncts.

The CPMA Seal is awarded to a product after the CPMA Seal of Approval/Acceptance Committee evaluates the product and determines whether the product promotes quality foot health.

ACCEPTED / ACCEPTÉ
CPMA
Canadian Podiatric Medical Association / L'association médicale podiatrique canadienne

If you use or know of a product that you think should be considered for the CPMA Seal of Approval/ Acceptance Program, or would like more information about the program, contact Jayne Jeneroux at jjeneroux@xplornet.com

**The CPMA's current list of companies with approved products include:**

Clarks (shoes)

FRS (cream)

McGregor (socks)

Ped A Ligne (various products)

Renfro (socks)

Simcan (socks)

Sox Marketing (hosiery/socks)

Striderite (shoes)

Wigwam (socks)


# Mark Your Calendar and Plan to Attend

## 2014 Dates

April 10-13
**Washington State Scientific Seminar**
**Campbell's Resort**
Lake Chelan, WA
http://wspma.org/annualmeeting.html

May 1-4
**Region 7/APMA Annual Conference**
Banff, Alberta
http://region7apma.org

May 2
**CPMA Annual General Meeting**
Banff Springs Hotel
www.podiatrycanada.org

May 2
**College of Podiatric Physicians of Alberta Annual General Meeting**
Banff Springs Hotel
www.albertapodiatry.com

May 24-31
**Mediterranean Greek Isles Cruise**
Mediterranean
http://www.internationalfootankle.org

June 13-14
**BCPMA Annual Scientific Conference**
**River Rock Casino**
Richmond, B.C.
https://www.bcpodiatrists.ca/annual-conference/online-registration

June 26-28
**10th Annual Seattle Summer Seminar**
Seattle
http://www.internationalfootankle.org

July 10-13
**APSSM Annual Meeting**
Seattle, Washington
www.sportsmed.org

July 10-14
**AOSSM Annual Meeting**
Seattle, Washington
www.sportsmed.org

July 24-27
**APMA Annual Scientific Conference**
Honolulu, Hawaii
www.apma.org

August 10-16
**International Association for Identification**
Minneapolis, Minnesota
www.theiai.org

September 11-14
**OPMA Annual Conference**
Toronto, Ontario
www.opma.ca

September 25-27
**20th Annual Las Vegas Seminar**
Las Vegas
http://www.internationalfootankle.org

October 11-18
**33rd Annual Hawaii/Maui Seminar**
Hawaii
http://www.internationalfootankle.org

October 17-19
**APMA Region One Conference**
Danvers, Massachusetts
www.podiatryinstitute.com

## 2015 Dates

July 23-26
**APMA Annual Scientific Conference**
Orlando, Florida
www.apma.org

## 2016 Dates

May 26-28
**FIP World Congress of Podiatry**
Montreal, Quebec
www.fip.org

July 14-17
**APMA Annual Scientific Conference**
Philadelphia, Pennsylvania
www.apma.org

## 2017 Dates

Aug 8-11
**Pacific Coast Conference**
Portland, Oregon
www.podiatryinstitute.com

# Loprox®

(ciclopirox olamine 1%)

## Prescribing Summary

### Patient Selection Criteria

**THERAPEUTIC CLASSIFICATION**

Topical Antifungal Agent

**INDICATIONS AND CLINICAL USE**

LOPROX® (ciclopirox olamine 1%) Cream or Lotion is indicated for the topical treatment of the following dermal infections: tinea pedis, tinea cruris and tinea corporis due to *Trichophyton rubrum, Trichophyton mentagrophytes, Epidermophyton floccosum, Microsporum canis*; cutaneous candidiasis (moniliasis) due to *Candida albicans*; and tinea (pityriasis) versicolor due to *Malassezia furfur*.

LOPROX® is not proposed for vaginal application.

**CONTRAINDICATIONS**

Hypersensitivity to any of the components of this medication (see Dosage Forms: Composition in the Product Monograph).

**SPECIAL POPULATIONS**

Use in pregnancy: (also see Supplemental Product Information): There are no adequate or well-controlled studies in pregnant women. This drug should be used during pregnancy only if clearly needed.

Use in Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when LOPROX® is administered to nursing women.

Use in Children: Safety and effectiveness in children below the age of 10 years have not been established.

### Safety Information

**WARNINGS**

LOPROX® is not for ophthalmic use.

**PRECAUTIONS**

If a reaction suggesting sensitivity or chemical irritation should occur with the use of LOPROX®, treatment should be discontinued and appropriate therapy instituted.

**ADVERSE REACTIONS**

LOPROX® is well tolerated with a low incidence of adverse reactions reported in clinical trials. LOPROX® Cream had a 0.4% incidence of adverse reactions in controlled clinical trials. These included pruritus at the site of application, worsening of clinical signs and symptoms, and mild to severe burning reported in a few cases.

In a controlled clinical trial with 89 patients using LOPROX® Lotion and 89 patients using the vehicle, the incidence of adverse reactions was low. The side effects included pruritus occurring in three patients and burning, which occurred in one patient.

To monitor drug safety, Health Canada collects information on serious and unexpected effects of drugs. To report a serious or unexpected reaction to LOPROX®, you may notify Health Canada by toll-free telephone at 1-866-234-2345.

### Administration

**DOSAGE AND ADMINISTRATION**

Gently massage LOPROX® into the affected and surrounding skin areas twice daily, in the morning and evening for a minimum of 4 weeks. Clinical improvement with relief of pruritus and other symptoms usually occurs within the first week of treatment. If a patient shows no clinical improvement after two weeks of treatment with LOPROX®, the diagnosis should be redetermined. Patients with tinea versicolor usually exhibit clinical and mycological clearing after two weeks of treatment.

### Study Reference

**1.** Kligman AM, *et al.* Evaluation of ciclopirox olamine cream for the treatment of tinea pedis: Multicenter, double-blind comparative studies. *Clin Ther* 1985;7(4):409-17.
Double-blind, multicentre study of 87 patients with both plantar and interdigital tinea pedis. Patients were randomized to either twice daily ciclopirox olamine 1% cream (*n*=43) or clotrimazole 1% cream (*n*=44) for four weeks.

**SUPPLEMENTAL PRODUCT INFORMATION**

**SPECIAL POPULATIONS**

Use in Pregnancy: Reproduction studies have been performed in the mouse, rat, rabbit, and monkey (via various routes of administration) at doses 10 times or greater than the topical human dose. No significant evidence of impaired fertility or harm to the fetus due to the use of ciclopirox olamine has been revealed. However, a higher incidence of systemic absorption of ciclopirox olamine in the rat was noted in the group given 30 mg/kg orally as compared to controls.

**SYMPTOMS AND TREATMENT OF OVERDOSAGE**

There have been no clinical reports of acute overdosage with LOPROX® (ciclopirox olamine) Cream or Lotion by any route of administration. From acute toxicity studies of ciclopirox olamine cream 1% in adult rats, oral doses of 36 g/kg produced no evidence of toxic signs.

**DOSAGE FORMS**

Availability: LOPROX® Cream is available in tubes of 45 g.
LOPROX® Lotion is available in a 60 mL bottle.

Product Monograph available upon request.


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PAAB

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to be **Victorious** in everything we treat

# Help your patients get antifungal relief fast with Loprox®

(ciclopirox olamine 1%)

## At week one, 93% of Loprox® patients showed improvement in tinea pedis

- Clinical response: 93% (*n*=43) of Loprox® vs. 71% (*n*=42) of clotrimazole patients; $p \leq 0.01$[1†]

Loprox® cream or lotion is indicated for the topical treatment of the following dermal infections: tinea pedis, tinea cruris, and tinea corporis due to *T. rubrum, T. mentagrophytes, E. floccosum, M. canis;* cutaneous candidiasis (moniliasis) due to *C. albicans;* and tinea (pityriasis) versicolor due to *M. furfur.*

Loprox® cream had a 0.4% incidence of adverse reactions in controlled clinical trials. These included pruritus at the site of application, worsening of clinical signs and symptoms, and mild to severe burning reported in a few cases.

† Recommended dosing: minimum 4 weeks, twice daily.

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to be **Victorious** in everything we treat

See prescribing summary on page 23