Katia Langton, CPed, CPed(C), DC

Vancouver Island, Canada

Canadian pedorthist/chiropractor shares experiences in treating the neuropathic foot and painful foot conditions

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As the O&P profession prepares for the Second O&P World Congress, to be held in conjunction with AOPA's 100th anniversary celebration September 6-9, in Las Vegas, the *O&P Almanac* is featuring a question-and-answer section with international O&P experts. Each month, we spotlight an O&P professional from a different part of the world to find out how O&P is practiced across the globe.

***O&P ALMANAC*: Describe a typical work day for you.**

KATIA LANGTON, CPED, CPED(C), DC: I work in both a private clinic and a public screening clinic, and in both clinics we see patients with foot, ankle, knee, hip, and low-back problems. I assess, risk-categorize, educate, and treat patients with the goal of keeping the patients on the ground and mobile so we can prevent chronic lifestyle-related diseases (of sedentary behavior), the largest being diabetes—the global pandemic with its complications of diabetic foot disease.

The public screening clinic is the Central Vancouver Island Foot and Ulcer Protection Clinic, a multidisciplinary clinic that provides diabetic foot screening and risk assessment to diabetic patients on a regular basis. We risk-categorize patients from a 0 to 3 scale, with 3 being assigned to patients who already have wounds or amputations.

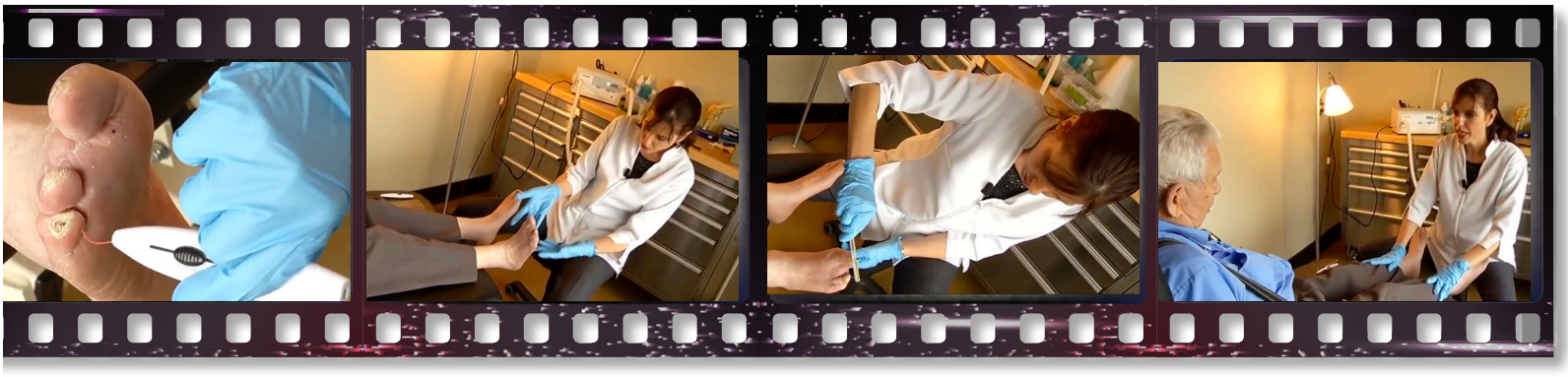
I am also the owner of Island Pedorthic FootCare, where we assess and treat diabetic patients aggressively in risk categories 1 and 2 to prevent progression to risk category 3. Our focus is preventative off-loading with diabetic orthotics, which will reduce the number of ulcerations and foot complications we will see in the future.

In both clinics we educate patients on neuropathy, and we also address toenail fungus aggressively when found in conjunction with the neuropathic foot as this increases the rate of foot complications.

Additionally, I lecture and teach health-care practitioners globally on differentially diagnosing the patients with stenosis and/or diabetic peripheral neuropathy. Stenosis—or neurogenic intermittent claudication—occurs when there is a degeneration of the lower spine, causing narrowing that puts pressure on the blood supply to the nerves of the back and lower extremities. This causes pain, cramping, and muscle weakness depending on where it is affecting the spinal cord. This pain mirrors and mimics diabetic neuropathy, but these must be differentially diagnosed and treated differently. Stenosis, which is prevalent in 60 to 70 percent of the aging population, can be reversible, but neuropathy is irreversible.

In my private clinic, I follow a protocol developed by the Mount Sinai Hospital in Toronto using spinal mobility and core stability exercises. Additionally, I use cold laser therapy to treat both spinal stenosis and painful diabetic neuropathy. For the neuropathic foot, we protect against ulcers and amputations by off-loading with accommodative diabetic orthotics and orthopedic shoes with rigid rocker modifications.

PHOTO: Katia Langton, CPed, CPed(C), DC



***O&P ALMANAC*: Describe the location where you provide services.**

LANGTON: My private practice, Island Pedorthic Footcare, is located in Nanaimo on Vancouver Island in British Columbia, Canada. The Central Vancouver Island Foot and Ulcer Protection Clinic is located nearby in a large clinic with 33 medical doctors. I spend about half of my time at each location. Additionally, I travel to multiple First Nations communities [equivalent to Native Americans in the United States] to provide foot-screening services.

***O&P ALMANAC:* What types of patients do you typically see, and what types of devices do you fit for these patients?**

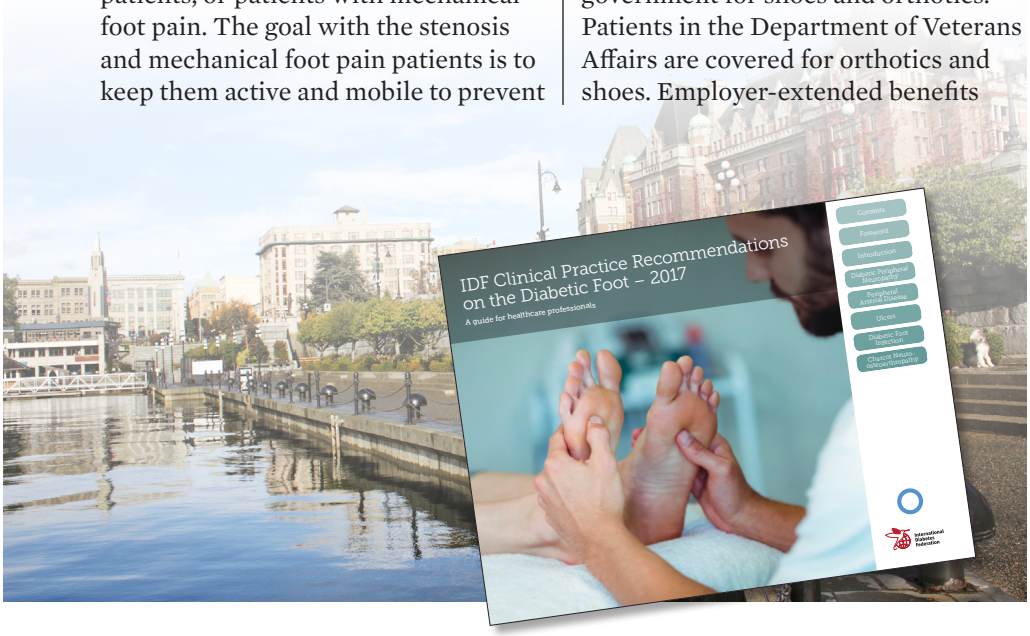
LANGTON: When a patient comes in, they are in one of three categories: stenosis patients, diabetic neuropathy patients, or patients with mechanical foot pain. The goal with the stenosis and mechanical foot pain patients is to keep them active and mobile to prevent them from becoming sedentary and possibly diabetic. I also treat a lot of posterior tibial tendon dysfunction, as we find it is under-recognized and misdiagnosed and therefore treated inappropriately. Because I am a doctor of chiropractic as well as a pedorthist, I can treat the whole body.

I use orthotics, footwear, and footwear modifications to treat neuropathy patients and mechanical foot pain. I use the stenosis protocol with cold laser therapy to treat stenosis patients. For ulcerations and Charcot foot, I use removable cast walkers, air casts, and off-loading wound shoes in order to close the wounds aggressively.

***O&P ALMANAC*: How are the devices you provide paid for?**

LANGTON: If patients are from First Nations, they are covered for orthotics by the government. Disability/Social Services patients are covered by the government for shoes and orthotics. Patients in the Department of Veterans Affairs are covered for orthotics and shoes. Employer-extended benefits cover orthotics and chiropractic. All of the above will cover off-loading wound shoes and removable cast walkers.

Patients who are not under any of those pay privately and have no coverage for off-loading wound shoes or removable cast walkers even if they are in grave danger of an amputation. However, prosthetic devices are covered after an amputation that was 85 percent preventable.



***O&P ALMANAC*: If the payor is other than the patient, do nonpatient payors have an audit process? If there is an audit process, do you consider it to be fair?**

LANGTON: We do not have an audit process. However, we do have to go through a lot of paperwork to get devices covered.

If we treat a patient from Disability/Social Services or First Nations, we don't get paid for the exams. We do have to complete paperwork, and we do get paid for the device, but not for the exam. We also have to be careful that exams are conducted within the proper time frames so that they are covered.

***O&P ALMANAC*: Describe your educational background and any certifications you have. How do you keep your skills sharp?**

LANGTON: I first studied and became a doctor of chiropractic, then I became a CPed, then a Canadian CPed(C). I've also taken several courses, such as the stenosis treatment protocol course, cold laser therapy, and advanced treatment of posterior tibial tendon dysfunction.

PHOTOS: Katia Langton, CPed, CPed(C), DC

I was appointed in April 2016 to the Diabetic Foot Stream Committee of the International Diabetes Federation (IDF), where we've been working for the past year or so on developing guidelines to prevent ulcers and amputations; these were just published in the document "IDF Clinical Practice Recommendations on the Diabetic Foot—2017" (*www.idf.org/our-activities/care-prevention/diabetic-foot.html*). I've done a lot of research in this capacity.

I lecture at conferences to all health-care practitioners on preventing diabetic foot ulcerations and amputations on a global level. Loss of protective sensation, coupled with limited joint mobility and foot deformities, leads to a predictable pattern and outcome of ulceration, Charcot arthropathy, and amputation. These are largely preventable—but little understood—by most health-care practitioners and patients.

Preventative off-loading will reduce the number of ulcerations and foot complications we will see in the future. Systematic adherence to international best practice guidelines will reduce overall costs and make health care sustainable in the future as diabetes progresses on a global level.

***O&P ALMANAC*: What's the biggest challenge you face as a practitioner, and how do you deal with it?**

LANGTON: Patients arrive in our clinics all the time and have never had a diabetic foot exam and have had diabetes for five, 10, 20, or 30 years. A lot of times, they already have advanced diabetic peripheral neuropathy, and sometimes they already have ulcers or a Charcot foot. These patients come in without any education, sometimes little funding available, and we have limited time and resources to educate, treat, and prevent deleterious complications with financial restraints. The patients are so thankful for the help and education and to have their mobility increased and a new lease on life if we can help them and protect their feet.

***O&P ALMANAC*: Describe any charitable work you or your organization does.**

LANGTON: I travel with my foot-care nurse, and we do a lot of diabetic foot screenings in our community and neighboring communities on a volunteer basis.

Working with the IDF to create diabetic foot guidelines is a volunteer appointment.

I do a number of educational conferences globally each year on a volunteer basis to teach prevention of diabetic foot amputations and ulcerations, including teaching at the Leprosy Hospital in Karigiri, India, in February 2017.

I'm also working on a research project with Edward Jude, MD, MRCP, a professor and endocrinologist in the United Kingdom; we are looking at patients who have been sent into wound clinics with neuropathy diagnoses who actually have stenosis—or both conditions. We will be presenting that research in Portugal later this year to raise awareness with health-care practitioners on the need to differentially diagnose these and refer for treatment for each condition separately. O&P