



The Science and Practice Management of Podopediatrics

Early intervention is the key to preventing future foot problems.



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There are millions of parents who are concerned about how their children run or walk. The problem for you is that they are told by countless professionals to do nothing, or sometimes worse, refer them to the wrong specialist. This sets up not only the problem of being able to treat patients who need help, but figuring out how to get them in your office. The problem with most childhood foot deformities is that poor biomechanics do exhibit the usual symptoms that feet do in adulthood. Many pediatricians feel the children will “grow out of it” and that what children are experiencing are “growing pains.” The fact, however, is that most people do not “grow out” of their foot problems, and those “growing pains” are actually a treatable foot issue.

The warning signs often observed by parents or healthcare professionals may be an antalgic gait, difficulty with walking/running, clumsiness, etc. (not always pain). While trying to remain clinically objective, it is important to “put your

self in parents’ shoes.” When parents see their child struggling and dealing with pain or discomfort, being told, “they will outgrow it” is often not an acceptable answer. So, before getting to the “how-to’s” of pediatric practice growth, let’s touch on the underlying biomechanics of it all.

Biomechanical Pediatric Age Groups

There are three characteristic and individual “biomechanical pe-

out walk, and will look like he or she has a collapsed ankle and severe flatfoot.

Most often, the parent will notice a coordination issue, postural issues, and/or trouble progressing with ambulatory milestones. In addition, if the child has a significant amount of heel eversion or valgus, a child’s core strength may be inhibited. This can impede a child’s normal milestone gross motor development. A child may be treated with an early intervention, but since

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diatric age groups.” Each differs in how we look at the pediatric foot.

Ages 1-4

For the age range 1-4 years old, children most likely will have a flatfoot. This is considered normal. The two treatable “foot” issues for this age range, whether or not a flatfoot is involved, are the degree of calcaneal valgus or heel eversion and/or the milestone/gross motor impairment created from a poor foot type/flatfoot, causing ankle instability. A child with a significant finding of calcaneal eversion will severely toe

the foundation is so poor, the physical therapy may not “stick” as well as if a child had a better-supported foundation. This “foundation” (or orthotic) is usually temporary and used to achieve more rapid gross motor achievement, which we see in practice every day. The orthotic must have a deep enough heel cup to adequately stop eversion (at least 25mm of depth or greater), a lateral wall to stop foot abduction, and functional control (firm enough material) to keep the rest of the foot well supported.

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Ages 5-9

For the age range 5-9 years old, a child's foot should not have a flat-foot appearance. This is an important message to impart to parents. A child in this age group who stands with a flatfoot should be treated with an orthotic. Once again, just like in a younger child, flatfeet at this age may not present with pain. Typically, pain is a rare symptom of a poorly functional foot type between the ages of 5-9. More commonly, children will experience balance, coordination, postural, or strength issues. As early as four years old, kids will begin to show their disinterest in running sports. They may not know why they don't "like" running sports, but they do know that their body is at a disadvantage. A thorough history of the "social choices" a child makes is an important part of the podiatrist's evaluation process.

For most of this age range it is recommended that orthoses should only control heel valgus (with deep heel cup rear foot posting). The forefoot, which is still in its "formative stages," usually does not need be extrinsically posted." This is the same criteria for orthotic foot (UCBL) control, as in ages 1-4.

Ages 10 and Above

Once a child hits the age of 10, as clinicians, we cannot necessarily treat kids as "kids." By this age, the true adult foot has formed. A child's foot type can be grouped into its final adult foot type category. We know that genetic make-up dictates a large component of one's foot type (www.whatsmyfoottype.com outlines these distinct foot types). In general, foot types can be sorted into six major categories. It is important to know exactly what foot type is involved before orthoses are prescribed.

Now that the principles of how to evaluate a pediatric foot biomechanically have been covered, here are some tips for cultivating a strong podopediatric component of your practice.

- Remember that no matter who your patient is, you are most likely treating something that is caused by poor biomechanics. As you know, poor biomechanics/poor foot types are genetic. This simple fact gives you a perfect reason to have your patient send in pediatric members of the family for a screening. Please feel free to have your patients go to websites like www.decaropodiatry.com and view the YouTube page of videos on pediatric foot care.

- Communicate to the patient the mantra "Correction is a poor substitution for prevention." Explain to your patient that all biomechanically-related podiatric issues are preventable if you intervene early enough, and intervening with an orthotic at an early age is the best solution to avoid future problems.

- Have your patients with a poor foot type stand next to their kids. If something looks similar or suspicious have them refer their child in! This one is a "no-brainer!"

- Give ALL patients whom you know have kids or grandkids handouts on what is "normal" and not normal regarding the "look of the feet," "growing pains," and pain that usually is not associated with the feet but actually is.

- Reach out to early intervention therapists in your community. They treat all kids 0-3 years old for low tone, muscular issues, slow gross motor development, etc. They see day-in and day-out flat feet and collapsed ankles. They are a great referral source!

Conclusion

In conclusion, treating the pediatric patient is not only vitally important to the future of each and every little foot you see, but can be highly rewarding for your practice. **PM**

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