Entry-Level Curriculum Recommendations for Foot and Ankle
Based on FASIG Consensus Task-Force meeting
Motion at CSM 2012:

Establish a multi-member task force charged with recommending the standard curriculum of foot/ankle content for graduates of an entry-level physical therapy program.

Enroll Group in Share Point Community
35 were enrolled by April of 2012 in an electronic group to share ideas/ documents/ and engage in debate.

Board report on 8/2012 included activity from the group to include 40 submissions and 16 documents.

Focus Group
A “phase 2” focus group to “compile” and complete a draft set of recommendations was planned.

15 members met in Arlington, VA at APTA headquarters on November 9-10.

Three groups tackled distinct parts of curriculum development

Normative Model
Numerous entry-level curriculum recommendations have been made by others across the APTA
“A Normative Model of Physical Therapists Professional Education: Version 2004 consists of a consensus-based model that reflects contemporary entry-level performance expectations for students who graduate from physical therapist professional programs.”

Examination Matrix
   Diagnosis
   Interventions
   Final Product

40 pages of recommendations

Ready to distribute for Phase II feedback

Next Steps...

Desire for Something “Usable”

Strong desire (and much discussion) about providing a usable and helpful product for educators
Resource for:
Teachers
Clinical Instructors
Students
Case studies may serve as an illustration of the recommendations

Stephanie Albin, DPT – Intermountain Healthcare, Utah
Clarke Brown, DPT, OCS, ATC – Brownstone Physical Therapy, New York
Christopher Neville, PT, PhD – Upstate Medical University, New York
Steven Pettineo, DPT, OCS, CSCS – Temple University School of Podiatric Medicine

**Case One**

RL is a 28 year old female who presents with lateral ankle pain since a twisting injury during a recreational softball game 2 weeks ago.

**History**
Determine severity, irritability, nature and stage of the complaint – ICF model

**Expectations:**
WHEN: acute / sub-acute / Chronic
HOW (Mechanism): Plantarflexion – Inversion
Dorsiflexion – Eversion
Pain Level / Outcomes measure: Foot Function Index
Treatment / Interventions already utilized
Past History of Sprains?

**Screening**

**Ottowa ankle rules**
Rule Out Fracture and appropriate signs and symptoms for PT care
Student completes and determines appropriateness for PT intervention
Neuro screen for sensation, myotomal weakness versus peripheral nerve injury

**Examination:** ROM
**Examination:** ROM / Lunge Test
**Examination:** Strength / MMT

**Examination:** Special Tests

**Examination:** Palpation

**Examination:** GAIT ASSESSMENT
Insert Video (not in folder)???
Diagnosis - History
Ankle in plantarflexion and inversion at time of injury
ruling out a syndesmotic sprain occurring in dorsiflexion and eversion

Diagnosis
Ottawa ankle and foot rules are negative
Ruling out differential diagnoses such as Lisfranc injuries and malleolar fractures

Diagnosis - Palpation
Pain over ATFL and CF ligaments
No pain over syndesmosis (helping to rule out high ankle sprain)
No pain over cuboid (helping to rule out cuboid syndrome)

Diagnosis – Range of Motion
Limited ankle dorsiflexion
In NWB position using a goniometer, MDC is 6° (Clinical practice guidelines, 2013)
In WB position, limited knee to wall or lunge test
Side to side difference greater than 13.88mm (MCID) (Simondson, 2012)

Diagnosis - Strength
?? Some studies show strength deficits in inversion and eversion strength and others do not (Clinical practice guidelines, 2013)

Diagnosis – Joint Mobility
Patient has limited posterior capsule glide
Student is able to identify this is a common finding post inversion ankle sprain

Diagnosis – Special Tests
Patient has positive anterior drawer test
Guides us to diagnosis of lateral ligament tear
Combination of pain with palpation of ATFL, lateral hematoma, and positive anterior drawer 5 days after injury had a sensitivity of 100%, specificity of 75%, positive LR of 4.13 and negative LR of .01 for lateral lig rupture
Pt has positive talar tilt
Increased inversion motion on the involved side compared to the uninvolved side

Diagnosis – Special Tests (cont)
Patient has a negative ER stress test and negative Tib-Fib Squeeze test
Student is able to identify when to use these tests in combination with history and palpation to rule out a high ankle sprain

Diagnosis
Swelling – Figure of 8
Greater than 6.8mm (MDC is 6.8mm) (clinical practice guidelines, 2013)

Special Tests Continued
Single Limb Balance Test - deficits
Special Tests – continued
Star Excursion Balance Test
Side to side deficits with anterior and posteromedial reach distances of greater than 4 cm - CAI

**Intervention**

Balance
Examples of activities?
Strengthening
Such as? Include options for progression
Patient response
Footwear
Structural features of shoe related to clinical condition for running population?
What would this look like?

**Interventions cont.**

Abnormal Motion
Excessive motion bracing, strapping
What would these options be?
Stirrup, heel lock,
Modalities
Select appropriate – such as?

**Interventions Cont.**

Patient Education
Injury prevention – self-management

Functional Training

**Case #2**

A 45-year-old female who works as an operating room nurse reports a 3-month history of insidious onset left heel pain. The pain is worse upon first weight bearing in the morning, after prolonged sitting, and at the end of the workday. She denies numbness or tingling. She does not complain of pain in other joints. The patient’s goal is to be able to walk 2 miles after work as part of a weight loss program

**History**
Examination: Foot Posture Index (FPI)
Examination: FPI Score

Examination: ROM

Examination: ROM / Lunge Test
Examination: STJ ROM
Examination: 1st MTPJ Mobility
Examination: Passive Toe Extension
Examination: Special Tests

Diagnosis - Palpation

Pain over the medial calcaneal tuberosity
Pain over mid-portion of central band

Diagnosis - History

Student is able to identify the history is consistent with plantar fasciitis
Increased start up pain – lessens with increased activity
Pain worse by end of day
No trauma
Work consisting of standing for long periods
No recent increase in activity – related to calcaneal stress fracture
Assess BMI - >30kg/m²

Diagnosis – Range of Motion

Limited ankle dorsiflexion
In NWB position using a goniometer, MDC is 6° (Clinical practice guidelines, 2013)
In WB position, limited knee to wall or lunge test
Side to side difference greater than 13.88mm (MCID) (Simondson, 2012)

Diagnosis – Special Tests

Patient has positive Windlass Test
Negative straight-leg raising test (with ankle dorsiflexion and eversion)
Rules out neurogenic component of tibial nerve

Diagnosis – Special Tests

Patient has a negative Dorsiflexion-Eversion Test
Helps student rule out the diagnosis of tarsal tunnel syndrome
Negative calcaneal squeeze test
Able to rule out stress fracture

Diagnosis – Special Tests (cont)

FPI
Patient presents with +10 – highly pronated foot

Diagnosis – Joint Mobility

Patient presents with limited joint mobility
talocrural posterior capsule glide limited
subtalar joint lateral glide limited