

Foreword



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Simplicity is the ultimate sophistication.

—Leonardo da Vinci

If it's working, keep doing it.

If it's not working, stop doing it.

If you don't know what to do, don't do anything.

—Dr. Melvin Konner

im•plant (im-plānt') *v*

1. To set in firmly, as into the ground: *implant fence posts.*
2. To establish securely, as in the mind or consciousness; instill: *habits that had been implanted early in childhood.*
3. *Medicine.*
 - a. To insert or embed (an object or a device) surgically: *implant a drug capsule; implant a pacemaker.*
 - b. To graft or insert (a tissue) within the body.

This issue of the *Clinics in Podiatric Medicine and Surgery* is titled “Implants,” and Dr. Jesse Burks and his invited authors have attempted to tackle an interesting and very controversial topic. Certainly there is a place for implant arthroplasty in salvage and reconstructive surgery of the foot and ankle, but it begs the question: Is this a panacea (from the Greek *pan-akeia*, meaning “all healing”) for foot and ankle surgery? Most would agree that it is not, any more than external fixation devices are a panacea for all

fixation needs. The keep it simple, stupid (KISS) policy does indeed serve us well from a surgical point of view—at least it does for me in many cases. After all, who can argue with success?

We all develop a certain familiarity and indeed a comfort level with surgical procedures over the course of time. I know for me, the distal chevron bunionectomy works well and seems to fit a fair number of my Hallux valgus surgical patients. I also find that the chielectomy buys my limitus patients a substantial amount of relief and return to near-normal function. Nevertheless, there is certainly a place for the insertion of a hemi or total implant in a significantly destroyed joint, and I have witnessed, first hand, the success of total ankle joint replacement. The key here is that it is never an all or none situation. To modify the words of Dr. Konner: if it is working, I keep doing it. If it is not working, I stop doing it, but that doesn't mean that it is not working in the hands of someone else, and I acknowledge and accept that fact.

The difference between a technician and a clinician is the *ability* to formulate a differential diagnosis, decide on ancillary testing to reach a diagnosis, and tailor a treatment plan that will have the greatest chance of success. Doing procedures just because “we haven't done one of those before” or because “we do that procedure all of the time” without regard for the individualization of each patient is just plain wrong. Choosing procedures that fit the patient's needs and work well in our hands...well, that's just plain old good medicine.

I look forward to reading this issue and to the authors' differing opinions regarding recommendations involving the use of implants. To implant or not to implant? That really isn't the question, but rather to choose a procedure that's best for the patient and works well in my hands or not. I think we all know the answer to that question.

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