TO: **All Licensed Podiatrists**
FROM: **Board of Podiatry Examiners**
DATE: **January 15, 2005**
RE: **Scope of Practice**

Please be advised that the Board of Examiners of Podiatrists has accepted the following resolution:

RESOLUTION

Be It Resolved that the Board accepts the opinion and recommendation of Attorney Thomas W. Stanton, who has been assigned to advise the Board. His opinion is that the scope of practice statute SDCL 36-8-1 appears to provide an extremely broad scope for podiatric physicians. His recommendation is that, however, the Board refrain from opining on specific procedures, particularly after another Board has issued an opinion that appears to be inconsistent with the statute. In such a situation, it would be up to the individual podiatric physician and his or her private legal counsel to determine the legal meaning of the relevant statute.

Petition for Declaratory Ruling
South Dakota Board of Podiatry Examiners
Pursuant to SDCL 36-1C-14 Submitted by:
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Avera Orthopedics

4/23/2026

Re: Request for Declaratory Ruling on the Transverse Tibial Transport Surgical Procedure and Scope of Podiatric Practice Dear Members of the South Dakota Board of Podiatry Examiners:

I am a licensed podiatrist in the State of South Dakota (License No. 246) board-certified by the American Board of Foot and Ankle Surgery (FACFAS), and actively practicing podiatric medicine and surgery. My hospital's credentialing/privileging board has requested that I obtain a formal declaratory ruling from the Board of Podiatry Examiners before granting hospital privileges to perform the transverse tibial transport (TTT) surgical procedure. This petition is submitted pursuant to SDCL 36-1C-14. To comply with the requirements of SDCL 36-1C-14, I provide the following information:

(1) The statutes or rules or order in question is: The primary statute in question is SDCL 36-8-1, which defines the scope of podiatric medicine as follows:

"Podiatric medicine is that profession of the health sciences concerned with the diagnosis and treatment of conditions affecting the human foot and their governing and related structures, and the soft tissues inserting into the foot, including the local manifestations of systemic conditions, by all appropriate systems and means."

This definition is interpreted and applied by the Board of Podiatry Examiners under the authority of Chapter 36-8 of the South Dakota Codified Laws. The petition process itself is governed by SDCL 36-1C-14 (part of the Uniform Complaint and Declaratory Ruling Procedures for healthcare licensing boards enacted via HB 1014 in 2021), which authorizes any person to petition a licensing board under Title 36 for a declaratory ruling on the applicability of a statute or rule to specific facts or circumstances. No specific administrative rules (ARSD 20:55) or prior board orders directly address the transverse tibial transport procedure.

(2) The facts and circumstances that give rise to the issue to be answered by the professional or occupational board or commission's declaratory ruling:

I am a practicing podiatrist in South Dakota with hospital privileges that currently include procedures such as total ankle replacements, application of external fixation devices, and surgical repair of ankle fractures. These procedures are permitted because they positively affect foot function and treat conditions of the foot and its governing/related structures, consistent with the broad language of SDCL 36-8-1.

The transverse tibial transport (TTT) procedure (also known as tibial cortex transverse transport or TBT) is a limb-salvage technique involving a controlled corticotomy and gradual transverse transport of a small segment of the proximal or distal tibial cortex using an external fixator. It is performed to treat chronic, non-healing wounds of the foot (most commonly diabetic foot ulcers on the heel or plantar surface) by stimulating neovascularization, angiogenesis, and improved perfusion to the distal lower extremity and foot. This directly addresses local manifestations of systemic conditions (e.g., diabetes, peripheral vascular disease) that impair foot healing and function.

My hospital's privileging board has determined that, prior to granting privileges for this procedure, a declaratory ruling from the Board of Podiatry is necessary to confirm whether TTT falls within the current statutory definition of podiatric medicine under SDCL 36-8-1. The procedure is performed on the tibia (a governing structure of the foot and ankle) specifically to improve foot function and promote healing of foot pathology. Podiatrists routinely manage the full spectrum of foot and ankle conditions, including those requiring surgery on related structures that impact foot health and function. Without this ruling, I am unable to offer this evidence-based limb-salvage option to my patients in South Dakota.

(3) The precise issue to be answered by the professional or occupational board or commission's declaratory ruling:

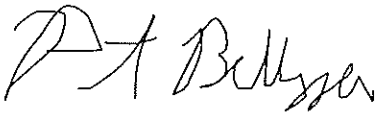
Does the transverse tibial transport (TTT) surgical procedure fall within the scope of practice of podiatric medicine as defined in SDCL 36-8-1 when it is performed by a licensed podiatrist to treat conditions affecting the human foot (such as chronic, non-healing diabetic foot ulcers) by improving vascularity and promoting healing through intervention on the tibia, a governing and related structure of the foot?

In other words, is TTT authorized under the current definition because it constitutes treatment "of conditions affecting the human foot and their governing and related structures … by all appropriate systems and means," consistent with the Board's prior recognition that procedures such as total ankle replacement, external fixation, and ankle fracture repair are within scope when they positively affect foot function?

I respectfully request that the Board issue a declaratory ruling at its next scheduled meeting (or within ninety days, as required by SDCL 36-1C-15) affirming that this procedure is within the scope of podiatric practice in South Dakota. I am happy to provide additional supporting medical literature, surgical technique descriptions, patient outcome data, or appear before the Board to answer any questions.

Thank you for your consideration of this important patient-care issue. I look forward to your ruling, which will allow me to continue providing comprehensive, evidence-based foot and ankle care, including advanced limb-salvage techniques.

Sincerely,



Peter Bellezza, DPM, MS, FACFAS
Licensed Podiatrist, South Dakota

Surgical Technique for Transverse Tibial Transport (TTT) / Tibial Cortex Transverse Transport (TCTT)

TTT is a minimally invasive distraction osteogenesis procedure based on Ilizarov's tension-stress principle. It creates controlled mechanical stimulation on the proximal tibial cortex to promote neovascularization, angiogenesis, and improved distal perfusion for healing chronic diabetic foot ulcers and limb salvage.

Key steps (typical protocol):

- Pre-op: Patient supine under anesthesia (often epidural or general). No tourniquet usually needed. Mark site on medial proximal tibia (typically 3–5 cm distal to tibial tuberosity) or it can be performed at the tibial plafond closer to the ankle joint.
- Incision & Corticotomy: Make small incisions (1–2 cm). Dissect to periosteum. Create a small unicortical rectangular bone window/segment (e.g., ~1.5–5 cm × 1.5 cm, variations exist) using multiple drill holes connected by osteotome. Preserve periosteum where possible to maintain vascularity. Avoid medullary cavity violation and anterior tibial crest.
- Fixator Application: Insert 2 unicortical half-pins into the transport segment and 2 bicortical pins proximal/distal in the tibia. Attach a monolateral external fixator for controlled transverse (medial-lateral) movement. This can also be done with a circular external fixator as well.
- Latency: 5–7 days of no distraction for initial healing.
- Distraction: Transport the bone segment ~1 mm/day (divided into 4 × 0.25 mm increments) for ~2 weeks (outward).
- Consolidation: Pause 3–7 days, then reverse transport back to original position at same rate (~2 weeks).
- Post-op: Immediate weight-bearing as tolerated. Pin-site care, wound management/debridement as needed. Remove fixator once wound healed and bone stable (often 4–8 weeks total). Monitor with serial X-rays.

Variations exist in bone window size, modified periosteal preservation, and exact timing. The procedure is often combined with standard wound care.

List of Selected Citations Demonstrating Improved Limb Salvage Rates

These studies (primarily systematic reviews, multicenter cohorts, and case series) report high wound healing (often >90–96%) and limb salvage rates (often 92–98%) with TTT for recalcitrant diabetic foot ulcers, with significant improvements vs. controls in many cases.

1. Hu XX, Xiu ZZ, Li GC, et al. Effectiveness of transverse tibial bone transport in treatment of diabetic foot ulcer: A systematic review and meta-analysis. Front Endocrinol (Lausanne). 2023;13:1095361. doi:10.3389/fendo.2022.1095361 (Pooled limb salvage rate 0.98; healing rate 0.96; superior to non-TTT controls).
2. Chen Y, Ding X, Zhu Y, et al. Effect of tibial cortex transverse transport in patients with recalcitrant diabetic foot ulcers: a prospective multicenter cohort study. Int J Surg. 2022;106:106937. doi:10.1016/j.ijsu.2022.106937 (94.9% healing; major amputation 4.9%; improved perfusion and quality of life).
3. Liu J, Kuang X, Zhou J, et al. Modified tibial cortex transverse transport for diabetic foot ulcers: a prospective study. Front Endocrinol (Lausanne). 2024;15:1334414. doi:10.3389/fendo.2024.1334414 (High effectiveness in wound healing and limb salvage via enhanced perfusion).
4. Wen Y, Li G, Zhang J, et al. Efficacy of tibial cortex transverse transport in treating diabetic foot ulcers: a retrospective study. Diabetol Metab Syndr. 2024;16:123. (Healing rate 92.3%; reduced amputation risk; improved circulation markers).
5. Yu L, Shang JX, Chen Y, et al. Tibial cortex transverse transport surgery improves wound healing in patients with severe type 2 DFUs by activating a systemic immune response: a cross-sectional study. Int J Surg. 2025;111(1):1234-1245. (Limb salvage 92.6%; high healing with systemic benefits).

Additional supportive literature includes U.S. case series/guidelines by Golshteyn et al. (2025) showing ~92% healing in small cohorts.