

*Australian Institute of Orthopaedic Technologists Inc.*

# A I O T newsletter

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- **Elements of a good cast**
- **Science of casting**
- **Identify the fracture**
- **Medical Terminology**
- **Crossword & Answers**

**May 2019**



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Cellona Cast Edge Padding is to be used for non-slip application at the edges of Plaster of Paris and synthetic casts and splints in all pressure-sensitive spots

- Increases wearing comfort for patient
- Self-adhesive
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On the cutting edge:  
protection of pressure-sensitive areas

Cellona Cast Edge Padding prevents pressure points while at the same time ensuring wearing comfort.

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### Ordering information

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<b>2mm thick</b>		
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[www.Lohmann-Rauscher.com.au](http://www.Lohmann-Rauscher.com.au)



# *Letter* from the President.

Hello AIOT Members,

Welcome to our first Newsletter for 2019, it is hard to believe that we have just finished the Easter break, I trust you enjoyed a safe holiday.

This year we are pleased to announce that our National conference and AGM will be held in Cairns on August 10th & 11th. The Conference is beneficial for all Cast room staff throughout Australia and is the only opportunity for our dedicated enthusiastic group to liaise and upgrade their knowledge and casting skills. Along with previewing new and improved materials, which are available on display from medical companies who continue to support our Association. For any further information on our up coming conference, please contact our Secretary Wendy Quinn at the Cairns Hospital.

The Certificate IV course news as stated previously is in the progress of being reviewed and upgraded by Skills IQ in Sydney. It is anticipated that it will be approved by ASQA (Australian Skills Quality Authority) and become available as a VET Course once again by mid 2020. It is hopeful that a Registered Training Organization will carry the course for future Trainees.

Please refer to the AIOT Website for information with regards to interim training for Queensland Health employees interested in pursuing a career in Orthopaedic casting, the super seeded AIOT Course has been approved by Queensland Health to train staff until the upgraded course is available. For members in other states and interested persons wanting to pursue a career in casting, please contact a state Liaison person in your state for further assistance.

Caroline Begg has stepped down as the newsletter editor due to other commitments. Thank you Caroline for your input and we wish you all the best.

Please enjoy this issue of our newsletter, it is proudly produced by our new editor, Jenny Dalton. As you aware Jenny produced the newsletter for many years, welcome back Jenny. Jenny will be assisted by John Kinealy.

Regards,  
Terry James  
AIOT President

## *How to contact us...*

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### *Newsletter Layout & Design*

*John Kinealy*

# AIOT CONFERENCE

10th-11th August 2019

## Cairns Hospital North Queensland

### Program Saturday 10th

- \* 8.30 am Registration & Trade Displays
- \* 9.00am Welcome & Conference Opening  
Terry James AIOT President
- \* 9.15am – Guest speaker (Orthopaedics)
- \* 9.45am – Guest speaker (Orthopaedics)
- \* 10.15am - Morning Tea & Trade Display
- \* 10.45am – Guest Speakers (Orthopaedics)
- \* 11.45am – Lunch & Trade Display
- \* 12.30pm- Breakout Practical session 1hr 30min.
  - \*Group One – Beginners practical session (upper & Lower limb Trauma slabs)  
Full POP Casting Colles / Smith' Greenstick/Buckle, Scaphoid,  
Metacarpal, Humeral Slabs, Below Knee.
  - \*Group Two – Intermediate Breakout Practical Session 1hr 30min.  
Full Synthetic casting Colles, Greenstick/Buckle, Scaphoid, Below Knee,  
Metacarpal.
  - \*Group Three – Advanced Group Breakout session 1hr 30min.  
Advanced casting PTB's, Total Contact cast's, Hip Spica (Paediatric, adult?)  
Paediatric fractures, Vascular issues in casting.
- \*2.00 pm – Afternoon Tea
- \*2.30 pm –Continue Breakout Sessions, 1hr 30min
- \*4.00pm – End of day one of Conference.
- \*4.00pm - AIOT AGM – All AIOT Members Requested to attend
- \*Saturday Evening AIOT Dinner function  
6.30pm – 7.00pm Pre dinner drinks – 7.00pm – 11.00pm Dinner & Drinks.

## **SUNDAY 11th August 2019**

**\*10.00 am – Welcome back – Open forum Discussion, casting Demonstrations, Certificate presentation.**

**\*11.00 am –Morning Tea**

**\*11.15am am- Practical Group/ individual Breakout sessions.  
1hr.15min session**

**\*12.30 pm - Annual National Scaphoid Race.**

**\*1.00 pm Close conference.**

### **Accommodation Options**

**\*[www.stayz.com.au](http://www.stayz.com.au)**

**\*[www.booking.com](http://www.booking.com)**

**\* Air bnb**

**\*Bay village Tropical Retreat, Corner of Lake & Gatton Street,  
Cairns Phone 0740514622**

**\*Ryldges Resort, Esplanade Cairns. 209-217 Abbott St, Cairns City  
Phone 0740449000**

**\*Cairns Rainbow Resort, 179 Sheridan Street, Cairns North  
Phone 0740511022**

# **See you there!**

# Madelung Deformity

*Jenny Dalton*

# M

adelung's deformity is an abnormality of the wrist caused by a growth disturbance that retards development of the ulnar and volar portions of the distal radial physis.

Carpus curvus, radius curvus, and progressive subluxation of the wrist, manus valgus, and manus furca are other terms used for this condition. The primary deformity is bowing of the distal end of the radius, which in the most typical form curves in a volar direction while the ulna continues to grow in a straight line.

The distal ends of the radius and ulna are at different levels in the lateral plane. That of the ulna has maintained its original normal position, while that of the radius has curved down to a volar level. It is the distal end of the radius that is displaced.

Because of its curvature and growth disturbance, the radius has become short while the ulna has continued to grow normally and has become relatively longer.

## *Etiology of Madelung Deformity*

There are four categories of Madelung deformity

- **Post-traumatic**  
Following trauma that disrupts growth of the distal radial ulnar-volar physis.
- **Dysplastic**  
Associated with bone dysplasias like multiple hereditary osteochondromatosis, Ollier disease, achondroplasia, multiple epiphyseal dysplasias, and the mucopolysaccharidoses. This type can also be seen secondary to sickle-cell disease, infection, tumor, and rickets.  
The most important dysplasia associated with Madelung deformity, however, is Leri-Weill dyschondrosteosis.
- **Chromosomal**  
As in Turner syndrome



<http://boneandspine.com>

- **Idiopathic**

Where no cause or association can be found. The exact nature of the pathologic process that causes the disturbance in the growth of the distal radial physis is unknown. When Madelung deformity is a hereditary disorder, it is transmitted as an autosomal dominant trait with incomplete penetrance. Sporadic forms do occur. It is more common in the females and involvement is frequently bilateral.

### *The Deformity*

Normally, the distal articular surface of the radius is tilted 5 degrees toward its volar surface and 25 degrees toward the ulna, with its dorsal surface and radial margin convex and its volar surface and ulnar border concave.

### *The normal wrist*



<http://i2.wp.com/boneandspine.com/wp-content/uploads/2008/12/normal-wrist.jpg>

### *There are two types of Madelung's deformity*

- Typical, or regular
- Atypical, or reverse.

In the typical form, the distal articular surface of the radius may tilt toward its palmar surface as much as 80 degrees and ulnarward as much as 90 degrees. In the normal wrist, the proximal row of the carpal bones is arranged in an arc, with its proximal surface forming a convex dome.



### *Xray of Madelung Deformity.*

Compare the slope of distal radial articular surface and carpal shift comparison to normal wrist on the previous page.

In Madelung deformity, this dome becomes peaked, its apex resting on the lunate bone. The radius and ulna are separated, with the peak of the carpal bones wedged into the interosseous space.

The entire carpus is shifted toward the ulnar and volar side of the wrist. Coalition of carpal bones may be present. In reverse, or atypical, Madelung deformity (it is rarer form), the distal end of the radius is tilted dorsally, reversing the plane of the distal end of the articular surface with a shift of the carpus toward the dorsal side.

The distal end of the ulna then appears to be displaced volarly instead of dorsally.

### *Pathophysiology of Madelung Deformity*

Primary chromosomal association with Madelung deformity has been observed in patients with Turner syndrome (Patients having only one X chromosome). Within families affected by a short stature dysplasia, a mutation has been found in short stature homeobox-containing gene, SHOX, present on X chromosome.

But families with this mutation and individuals with Turner syndrome and families with a history of MD have been shown to exhibit a variable expression of MD and dyschondrosteosis. These raises a possibility of a modifier gene on another area of the X chromosome or on an autosomal gene may be involved.

### *Clinical Presentation*

Deformity of the wrist is the initial presenting complaint; it usually becomes obvious in late childhood or early adolescence, between the ages of 8 and 12 years.

In typical Madelung's deformity the distal end of the ulna remains in its normal anatomic position and grows distally, causing a visible prominence on the dorsal and ulnar aspects of the wrist. Normally, the radial styloid process is long and is located 1 cm distal to the ulnar styloid. In Madelung's deformity, the radius is shortened at the wrist;

Normally, the radial styloid process is long and is located 1 cm distal to the ulnar styloid. In Madelung's deformity, the radius is shortened at the wrist; the radial styloid process may be on the same horizontal line as the ulnar styloid or may reach a point proximal to it.

The range of motion of the wrist is limited, especially in dorsal extension and ulnar deviation. Because of the diastasis between the distal radius and ulna and the displacement of the carpus between the two separated bones of the forearm, pronation and supination of the forearm are also limited; as a rule, supination is definitely decreased, and pronation is impaired to a slight degree.



In reverse Madelung's deformity palmar flexion of the wrist is decreased, while dorsiflexion is increased. Range of rotation in of the forearm, especially pronation, is decreased. When it is minimal, Madelung's deformity may be asymptomatic.

In moderate or severe deformity, however, pain develops insidiously at the wrist.

Initially it is minimal, disappearing on rest. With progression of the deformity and impingement of the displaced carpus on the distal ulna, the pain increases. Volar displacement of the carpus may cause discomfort in the region of the median nerve and flexor tendons. Weakness of the wrist may result from progressive instability of the joint.

## Imaging

- X-rays

Characteristic radiographic findings include dorsal and radial curvature of the distal radius; exaggerated palmar and ulnar tilt of the distal articular surface of the radius; pyramiding of the carpal bones; greater length of the ulna as compared with the radius; wide interosseous space; and assumption of a relatively dorsal position by the ulnar head, which appears to be enlarged.

- CT

CT scan provides better details of three dimensional deformities though CT scans and 3-dimensional imaging are not necessary for routine treatment.

- Differential Diagnoses

Trauma (dislocation of the distal radioulnar joint), rickets, inflammatory conditions of the wrist such as rheumatoid arthritis, and infection involving the ulnar half of the distal radial physis.

- Treatment

Treatment is primarily directed toward the relief of pain and the restoration of function, with cosmetic improvement as a secondary consideration.

The majority of patients with Madelung's deformity do not require surgical treatment.

Conservative measures consist of curtailing physical activities that may cause forced dorsiflexion of the wrist and wearing a plastic wrist splint to provide support and relieve symptoms.

Surgical treatment options are

- Shortening the ulna – Milch's cuff resection in children or Darrach's resection.
- Correcting the bowing deformity of the distal radius by wedge osteotomy
- Stabilization of the carpus
- Prevention of recurrence of deformity by controlling the asymmetrical growth of the distal radius.

Deformity correction is achieved by either a closing wedge or an opening wedge osteotomy of the distal radius at its metaphyseal-diaphyseal junction. Fusion of the radial half of the distal radial physis will prevent recurrence of deformity.

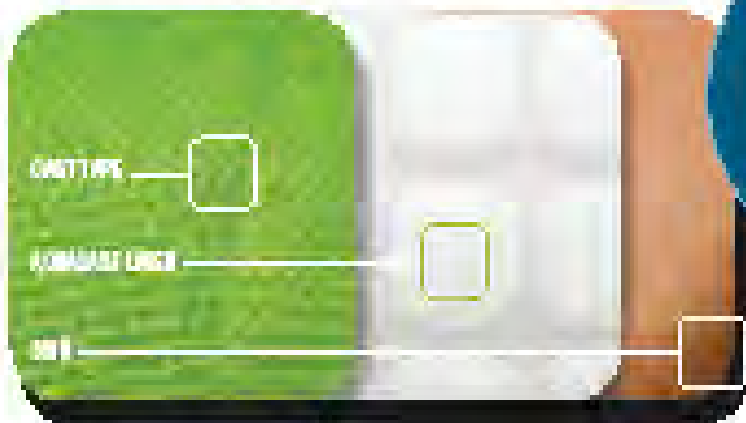




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# Elements that should be demonstrated to achieve a good cast

*Jenny Dalton*

1. Effective cast moulding (e.g., three-point mould, Dorsal or volar).
2. Appropriate cast length.
3. Effective padding between the skin and casting material, especially where bony prominences are located.
4. Proper functionality of mobilised joints (both proximally and distally) just adjacent to the joint immobilized by a cast.
5. Cosmetic appearance of the cast applied no rough edges.
6. Effective documentation.
7. Observe that the neurovascular status of limb to is within normal limits.
8. Check the fit and functionality of cast.
9. Provide client and carer with written and verbal advice for care of cast and limb.
10. Fit client with sling, heel/overshoes and ambulation aids, as required.
11. Instruct client on correct use of ambulation aids and ensure client is safe.
12. Arrange appropriate support for client.
13. Clean equipment in accordance with manufacturer's specifications and stored safely.
14. Clean work surfaces in accordance with infection control guidelines.
15. Identify different types of moulding required for wrist fractures.
16. Have an understanding to why we mould a cast.
17. Feel more confident to mould.
18. Follow up with the doctor post application x-ray to see if the moulding is acceptable.
19. To be able to have it critiqued by doctor afterwards and handle constructive criticism.
20. Evaluate and make judgements.
21. Comprehend and interpret any direction provided.
22. Confident enough to ask for advice and know ones limitations.
23. Able to query professionally if doctors instructions are not fully understood.



## Waterproof Protection for casts, dressings & PICC lines

- ✓ **DRESSING & CAST PROTECTION**  
Protect plaster casts and wound dressings from getting wet during bathing or showering. It can also be used for swimming and hydrotherapy.
- ✓ **COMFORTABLE TO WEAR**  
There is a cellular neoprene seal which has a wide band of contact and therefore does not pinch the skin or feel constrictive.
- ✓ **DURABLE**  
It will last through the period a cast should be worn.



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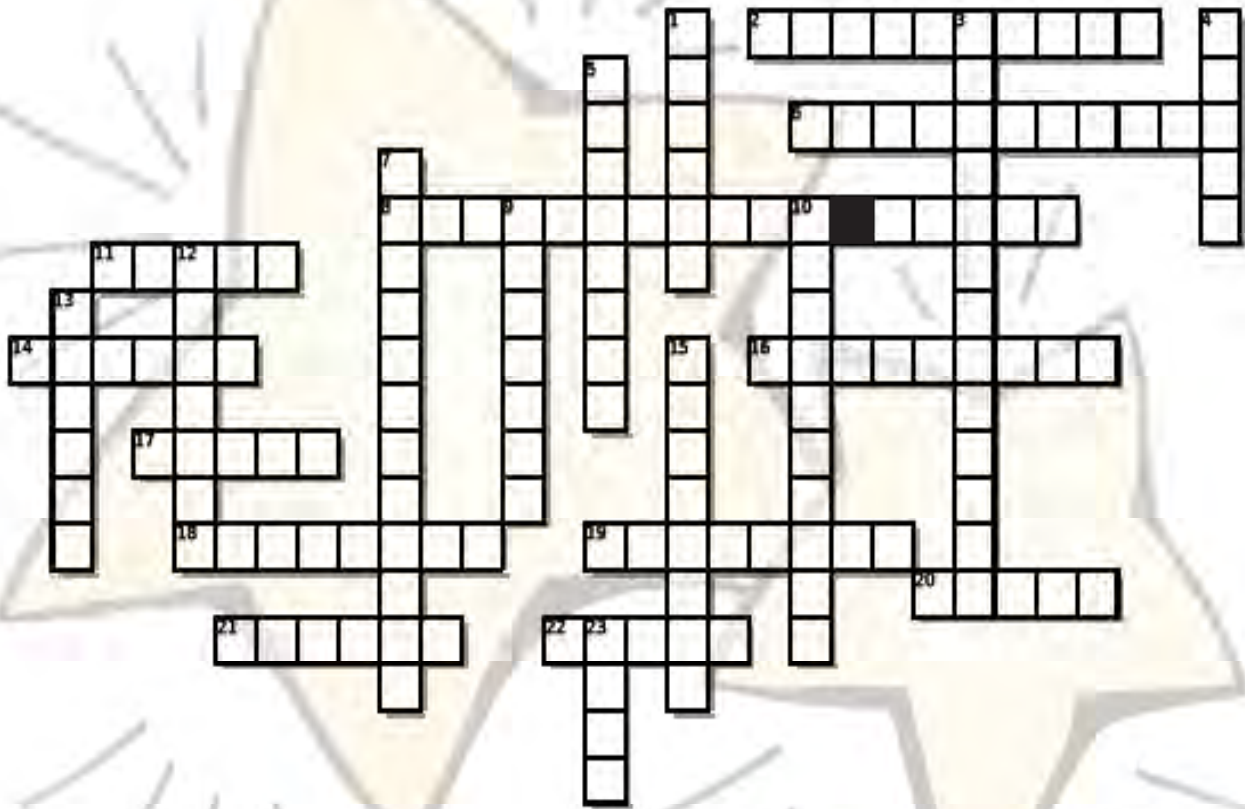
 Limbo Cast Protectors. Manufactured in the UK. Imported into Australia exclusively by HealthSaver 

[www.healthsaver.com.au](http://www.healthsaver.com.au)

# Crossword

## fractures

Jenny Dalton



### ACROSS

- 2 caused by a direct blow to the forearm
- 6 what a Colles type fracture is through?
- 8 longest phase of fracture healing
- 11 classification
- 14 neck of metacarpal bone
- 16 fractured in two places, floating
- 17 bulge in cortex bone
- 18 snuffbox
- 19 small without displacement
- 20 produced by a blunt force
- 21 extending down along the length of a bone
- 22 avulsion 5th metatarsal

### DOWN

- 1 metaphyseal compression fracture of a long bone
- 3 fatpad
- 4 comminuted intra-articular of the distal tibia due to impaction of the talus into the tibial plafond
- 5 fracture dislocation
- 7 through both lateral and medial of the ankle joint
- 9 obliquely to the long axis
- 10 incomplete break in one side of cortex
- 12 fracture dislocation of the wrist joint
- 13 lower end of the radius is displaced backwards
- 15 fails to unite
- 23 compound

*Answers on the last page.*

# Science of casting...

Kristin McCann  
Orthopaedic Technologist  
Western Hospital, Victoria

As a P&O and an orthopaedic technologist, I believe I bring a unique skill set to my work place. I work in a busy public hospital where a large portion of our case load is fracture treatment. With the rest being made up by soft tissue injuries and High risk foot patients, from both Orthopaedics and Podiatry.

By treating this diverse group of patients, my Casting, Splinting and bracing skills have been finely honed. Using materials such as POP, Fibreglass and Polyester, as well as high and low temperature Thermoplastics, has allowed me to become fluent and efficient in the application process. Some may say I am an all rounder, I've mastered the artistry! But one component is missing, the science. This is a really important component of safe treatment and something I work really hard to achieve.

When I receive a referral I am presented with a patient who has an injury or condition. I could just apply the cast or splint as requested and fulfill the request. Anybody can apply a cast or splint, but is it safe? Am I managing and holding the limb correctly?

Prior to the application process ask yourself these questions;

- \*What injury am I treating
- \* Have I viewed the most recent x-rays
- \* How old is the injury
- \* How stable is the injury
- \* Do I understand the fracture type, level, displacement or angulation if any is present
- \* Is there any rotation
- \* Is a full cast justified?
- \* If moulding is required do I understand the points and direction
- \* Have I explained the process to the patient and gained their consent
- \* What position do I place the limb in
- \* How do I hold and stabilize the limb whilst casting
- \* Do I require assistance
- \* Do I apply more or less padding
- \* Do I need to modify my application process (more or less time required)
- \* Are there any anomalies that need to be reported (swelling, abnormality, infection etc)
- \* Have I gathered all the materials and equipment required
- \* Is the patient, applicator/assistant positioned as reasonably comfortable and safe as possible
- \* Did I do a neurovascular check.
- \* Have I provided cast and limb care and reinforced what to do if problems arise
- \* Have I provided any aides and explained their safe usage
- \* Have I offered the patient or Guardian the opportunity to raise any concerns
- \* Have I cleaned the work area
- \* Disposed of waste appropriately & safely
- \* Documented or filed any paperwork

Understanding the injury ensures safe handling and treatment because there is knowledge of the type, mechanism and level of the underlying injury. This is the science.

Fractures occur by three ways;

- \* Acute trauma  
These fractures account for the majority of our work. They can be categorized as direct trauma (fracture occurs at the site of the injury). Or, indirect trauma such as an avulsion fractures.
- \* Fatigue fractures  
These are Stress type fractures that are caused through repetition.
- \* Pathological fractures  
Occur through diseased bone.

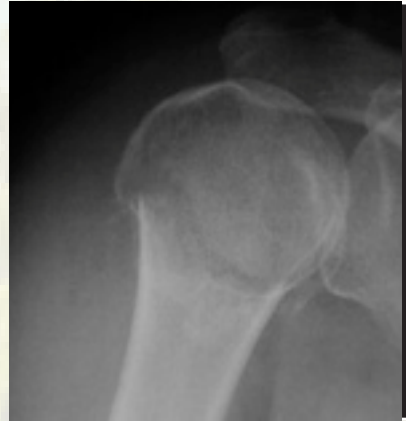
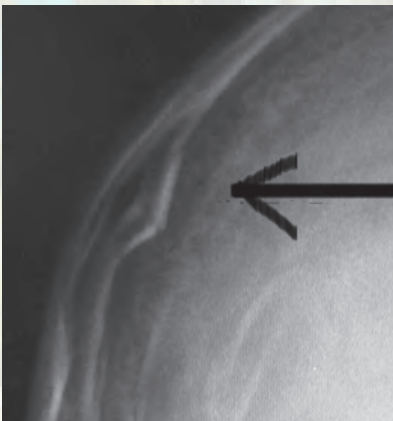
Have a look on the following pages and see if you can identify these fractures on x-rays and understand the mechanism that caused them. Good luck and keep working on the science of our profession.

## References;

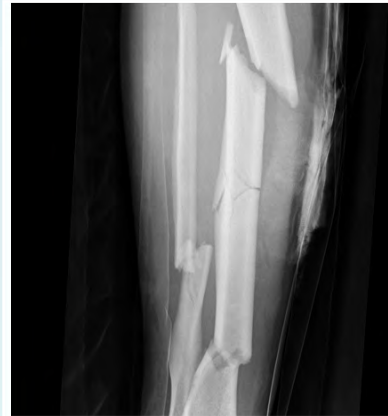
- \*Garland J.J. M.D., 1987. *Fundamentals of Orthopedics fourth edition. Philadelphia, PA: W.B. Saunders*
- \*Rockwood Jr., Charles A M.D., David Green M.D., Robert Bucholtz M.D.,. 1991 *Fractures in Adults third edition. Philadelphia, PA: JB. Lippincott.*
- \*Turek, Samuel, L. M.D., 1984. *Orthopedics principles and their Application Fourth edition. Philadelphia, P.A.: JB. Lippincott.*

Kristin McCann, Orthopaedic Technologist Western Hospital Victoria

# Identify these fractures

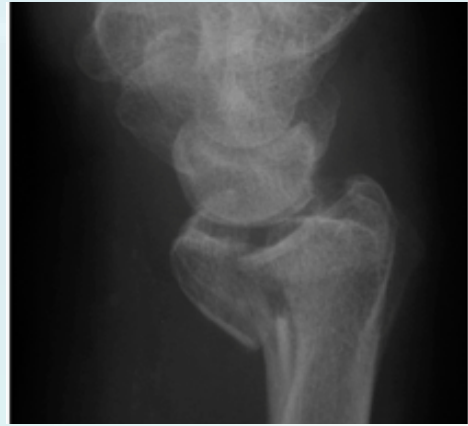


# Identify these fractures *continued*





# Identify these fractures *continued*



# Medical Terminology

*Kristin McCann, Orthopaedic Technologist Western Hospital Victoria*

Medical terminology is an essential component of any healthcare profession. Test yourself first with these root words, followed by Prefixes on the next page. Start with what you know, and then find the answers and examples of the ones you don't. Keep working on them until you know them all.

<i>Roots</i>	<i>Meaning</i>	<i>Example</i>
ADEN	.....	.....
ANGIO	.....	.....
ARTH	.....	.....
BLEPHAR	.....	.....
CARDI	.....	.....
CEREBRO	.....	.....
CEPHAL	.....	.....
CERV	.....	.....
CHOL	.....	.....
CHONDR	.....	.....
COST	.....	.....
CRANI	.....	.....
CYSTO	.....	.....
CYT	.....	.....
DACTYL	.....	.....
DERM	.....	.....
ENCEPHAL	.....	.....
ENTER	.....	.....
GASTR	.....	.....
GLYCO	.....	.....
HAEM	.....	.....
HEPAT	.....	.....
HYSTER	.....	.....
LEUK	.....	.....
LIP	.....	.....
LITH	.....	.....
MENING	.....	.....
MAST	.....	.....
METR	.....	.....
MY	.....	.....
NEPHR	.....	.....
OPHTHALM	.....	.....
OSTEO	.....	.....
PHLEB	.....	.....
PNEUM	.....	.....
PROCT	.....	.....
PSYCHO	.....	.....
PYEL	.....	.....
PYO	.....	.....
SALPING	.....	.....
SPONDYL	.....	.....

<i>Prefix</i>	<i>Meaning</i>	<i>Example</i>
AB	.....	Abnormal
A, AN	.....	Anaesthesia
AD	.....	Adhesion
ANTE	.....	Antenatal
ANTI	.....	Antipyretic
BI	.....	Bilateral
CONTRA	.....	Contraception
DYS	.....	Dysmenorrhoea
ENDO	.....	Endocardium
EPI	.....	Epidermis
ERYTHRO	.....	Erythrocyte
EX	.....	Exophthalmos
HEMI	.....	Hemiglossectomy
HYPER	.....	Hypertension
HYPO	.....	Hypoglycaemia
PARA	.....	Paranoia
PERI	.....	Pericardium
POLY	.....	Polyuria
PRE	.....	Premature
SUB	.....	Subcostal
PRO	.....	Prolapse
RETRO	.....	Retroversion
SEMI	.....	Semiconscious
SUB	.....	Subcostal
SUPER/	.....	Superabduction
SUPRA	.....	Suprapatellar
SYN/SYM	.....	Syndactylism
TRANS	.....	Transection
TRI	.....	Trimalleolar

*Try reconstructing these sentences.*

*Choose a word that describes the bold italicized word/s*

- The patient has fractures in ***both legs***.  
The patient has ..... lower limb fractures.
- The patient has a ***fracture of both medial and lateral malleoli***.  
The patient has a ..... fracture.
- Children have a very thick ***lining around their bones***.  
Children have a very thick .....
- Some fractures of the scaphoid are prone to have the ***closer*** fragment of bone ***die*** due to ***no***, or ***lack of blood supply***.  
Some fractures of the scaphoid are prone to have the .....  
fragment of bone die due to ..... also known as  
(***abb***) ....

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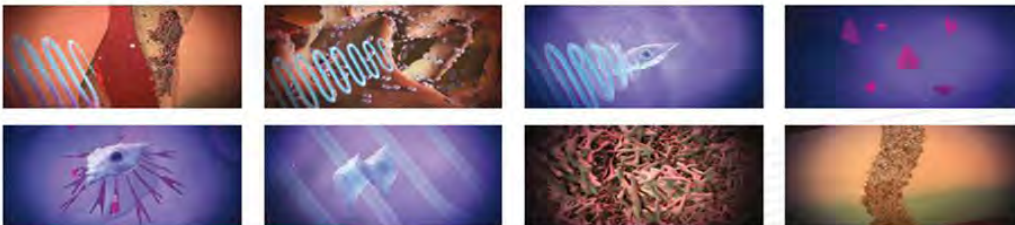
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CMF OL 1000 POSTMARKET PATIENT REGISTRY DATA			
BY SITE	HEALED # TOTAL #	OUTCOME RATES	AVERAGE HEAL TIMES (MONTHS)
ANKLE	110 / 145	75.9%	4.7
CARPAL NAVICULAR	154 / 218	70.6%	3.9
CARPAL / METACARPAL	35 / 39	89.7%	5.3
CLAVICLE	79 / 114	69.3%	5.1
FEMUR	160 / 250	64.0%	6.4
FIBULA	58 / 68	85.3%	4.3
HUMERUS	103 / 180	57.2%	5.5
METATARSAL	408 / 477	85.5%	3.8
PHALANX (FINGER)	21 / 24	87.5%	3.4
PHALANX (TOE)	22 / 29	75.9%	3.7
RADIUS	81 / 96	84.4%	5.0
RADIUS / ULNA	14 / 17	82.4%	5.3
TARSAL	51 / 77	66.2%	4.3
TIBIA	285 / 372	76.6%	6.2
TIBIA / FIBULA	122 / 154	79.2%	5.8
ULNA	77 / 110	70.0%	5.0
TOTAL (POSTMARKET)	1780 / 2370	75.1%	4.9

**89%** CMF has a heal rate of up to 89%

**30 min** 30 minute treatment, only once a day

**0 need** Zero need to cut a hole in cast for treatment



**Enquiries :**

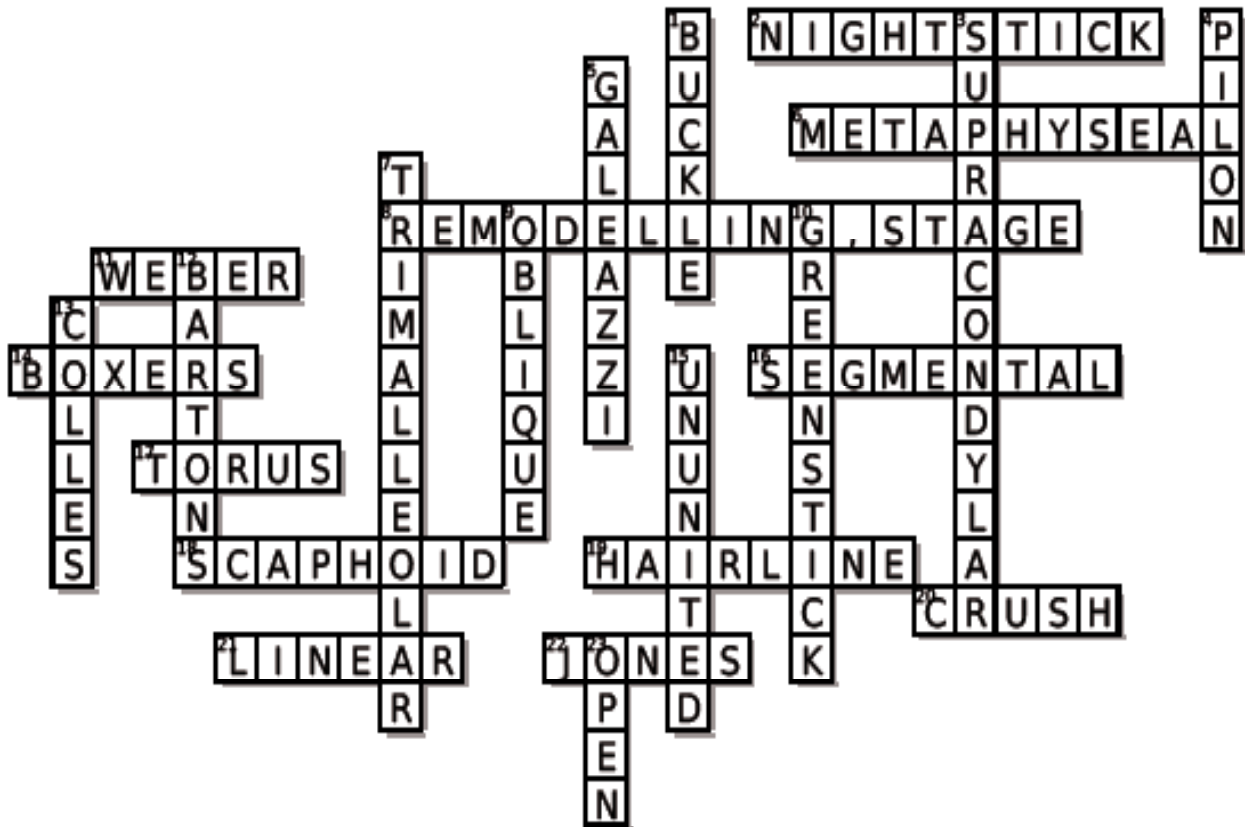
T 1300 66 77

[CustomerService.AU@djoglobal.com](mailto:CustomerService.AU@djoglobal.com)

[DJOglobal.eu](http://DJOglobal.eu)

# Crossword Answers

## fractures



## Who am I ?

*Jenny Dalton*

Below are the hints for who am I. Cover the up hints except for number one and see if you can guess. The hints get easier as you go down.

1. I am found at the metaphyseal/ diaphyseal junction.
2. I am a fracture.
3. The weight of the body has carried over the top, causing the slight kink on the dorsal aspect.
4. I am usually in children

# Errol Bourne from North West Regional Hospital in Burnie Tasmanian

I caught up with Errol and I noticed he had his trophy proudly on display for winning the annual Scaphoid race in Cairns 2013.

Get practising for Cairns 2019!!

Good to see you again Errol.

John Kinealy



## Doctor Geezer

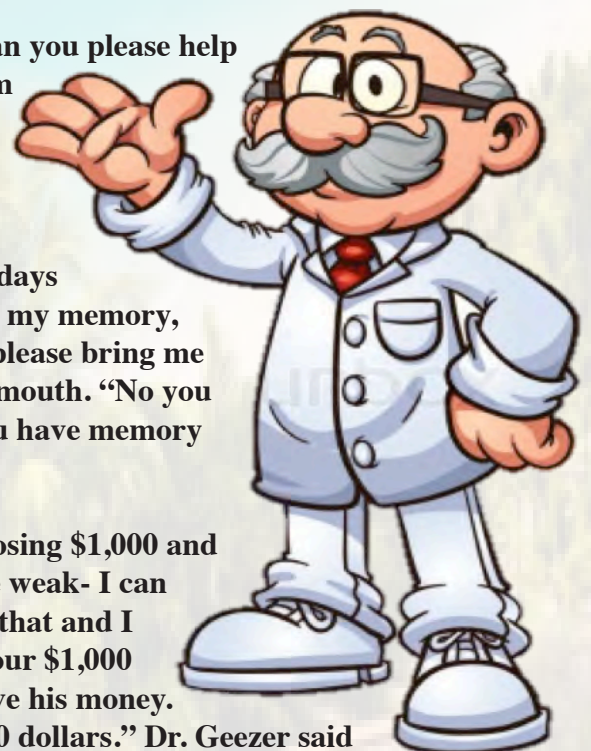
### A joke from and old geezer and an old friend Glenn Brown.

An old physician Doctor Gordon Geezer became very bored in retirement and decided to re-open a medical clinic. He put up sign up outside that said “Dr. Geezer’s clinic. Get your treatment for \$500- if not cured, get back \$1,000. Dr. Digger Young saw the sign and was positive this old geezer didn’t know beans about medicine. He thought it was a great opportunity to get \$1,000 so he went to in to Dr. Geezer’s clinic.

Dr. Young “Dr. Geezer, I have lost all taste in my mouth, can you please help me please?” Dr. Geezer “Nurse, please bring medicine from box 22 and put three drops in Dr. Young’s mouth.”  
Dr. Young “Aagh this is gasoline!” “Congratulations, you have your taste back, that will be \$500.”

Dr. Young is very annoyed and goes back after a couple of days figuring he can get his money back. Dr. Young “ I have lost my memory, I cannot remember anything” he said. Dr Geezer “Nurse, please bring me medicine from box 22 and put three drops in the patient’s mouth. “No you don’t, that’s gasoline” said Dr. Young. “Congratulation you have memory back, that will be \$500” said Dr. Geezer.

Dr. Young waits several days and is now very angry after losing \$1,000 and returns to get it back. Dr. Young, “My eyesight has become weak- I can hardly see anything.” “Well I don’t have any medicine for that and I can’t cure you.” said Dr. Geezer. “I will have to give you your \$1,000 dollars back.” Smugly Dr Young put out his hand to receive his money. He looked down at his hand and yelled out ‘That’s only \$10 dollars.’ Dr. Geezer said ‘Congratulations you have your eyesight back, that will be \$500.’



Moral of the story- just because you are young doesn’t mean you can outsmart an old geezer!