

# Ankle and Foot

with Pinak Ray  
27<sup>th</sup> May 2020

## TRANSCRIPT

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Steven:

We're going to be talking about something which is very close to our hearts this lunchtime, that is the foot and the ankle. My guest is Mr Pinak Ray who is a consultant trauma and orthopaedic surgeon in London. He's been a doctor for over 35 years and a consultant for the last 15. His particular interest is in ankle and foot fusion, arthro-plasty and also tendon injuries. Pinak great to have you join us, thank you for coming.

Pinak :

Thank you very much. Thank you for inviting me.

Steven:

I was going to say before we get into this, that you've actually, I don't want this to sound too dramatic, you've actually changed my life today because I have never ever subscribed to Instagram. I've avoided it like the plague. And yet on your website it says that you have an interest in cooking and it gives a reference to Instagram. And I had to sign up to an Instagram account to look at it.

Steven:

And you know, I think your Instagram account is ortho underscore chef, isn't it? And there's a whole lot of photographs there and some great recipes behind them.

Pinak :

Thank you very much. I'm an amateur chef, and I love cooking, and that's one of my pets.

Steven:

I'll tell you what people are going to ask though is: you are clearly dressed in scrubs so people are going to be interested in to what extent you are actually practicing your real art, your surgery at the moment.

Pinak :

So trauma surgery has started in my hospital and we are doing regular trauma surgeries. Although the numbers we can do in a day is less than what we used to do before for the donning and doffing, but we have started in earnest and believe you me, when we opened our doors it got busy day one.

Steven:

Really?

Pinak :

Yeah. Yeah.

Steven:

Well I'm pleased to hear it. And actually then I'm doubly grateful that you've given up some time to join us for lunch time here. But, so one of the things which bothers us is osteopaths, chiropractors, physios and so on, of course is diagnosing what is wrong with a painful foot or an ankle. Can you offer us any help with that?

Pinak :

Yes, of course. I've got something to share with you I want to let everybody know that a foot and ankle is a complex structure. There are 26 bones

Steven:

And it looks as though I was zoom connection is playing silly buggers. One is the Corona virus. It affects so many structures. Pinak now can you still hear us?

Pinak :

Yeah, I can hear you again now too. You can't see my screen?

Steven:

Yeah, we've got complex anatomy on the screen now.

Pinak :

Okay. So as I said that to me it's very complex. There are a number of bones and 33 joints, multiple tendons and ligaments and each one of them can be a problem and patients will come to you and will tell you that they have a pain in one or two particular areas in the foot and ankle. I'm just going to go through a journey through the forefoot, midfoot, hind foot, and the ankle and show you how from the site of pain we can come to generally the right diagnosis in foot and ankle.

Pinak :

If you take a topographic anatomy, you can see at the back of the heel you have the Achilles tendon. On the, on the lateral side, on the outer side you have the peroneal tendons. On the top would be most of the extensors and extensor tendons. On the inner side will be the tibialis posterior tendon and on the plantar aspect of the foot, the plantar fascia. But, most important in foot and ankle diagnosis is history and the site of pain. What I'll do is I'll just go through the certain parts of the of, of the foot and ankle and say, where you would look for pain and make a diagnosis. So you can see the first photograph. It's very obvious it's a bunion deformity. A Hallux valgus pain is on the inner side of the big toe. Usually when you see a bunion, make sure that it is not a swelling on the top of the big toe because the swelling on the top of the big toe is not defined as a bunion. Most probably it's because of arthritis and it's called a hallux rigidus, but if a patient comes in, tells you that they have pain in the under surface of the big toe, that means when they're running, walking, wearing shoes, maybe high heels, if they get painful under surface, think about sesamoiditis.

Pinak :

If they have pain on the top of the lesser toes, usually the second and the third. Think about synovitis, inflammation. Some of them will come with no deformity. Think about something called a Freiberg's. Can you see this x-ray? X-ray shows a damage to the head of the second metatarsal. This is an avascular condition in which there is an avascular necrosis and arthritic changes in pain and discomfort. Sometimes patient will come with pain under the plantar aspect of the foot. Look at the plantar aspect of the foot. It will tell you a lot of the story that is happening in the forefoot. You will see this callosities when you see these callosities, most probably they have a dropped transverse metatarsal arch and when that is dropped and they are walking on it, they get these hard skin under. But if a patient comes and tells you that they have pain under, in the under the forefoot, can you see

where the thumb is? Yes. You look at the under surface of the, of the, of the forefoot. If you don't see a callosity, but if the patient has come and said that they get this pain whenever they walk, maybe associated with numbness, tingling and numbness in the toes, very commonly between the third and the fourth toe, but not uncommon between the second and the third toe. Think about a Morton's neuroma.

Steven:

How much weight do you attribute to the Mulder's click when you're looking for Morton's neuroma?

Pinak :

Mulder's click is very sensitive and I would think it is quite a pathognomonic test of a Morton's neuroma but it will not specifically tell you which intermetatarsal space it is. But I would do that test. But however, sometimes when you have just an intermetatarsal bursae, it can also give you a Mulder's test and therefore they can be false positives and those, therefore the investigation of choice is an ultrasound scan which will tell you whether there is a Morton's neuroma or an intermetatarsal bursae.

Steven:

Would the symptoms be similar?

Pinak :

Very similar. If you, the deformities in the, in the toes are quite obvious. You can see callosity of the proximal interphalangeal joint. It is a hammer toe but if there's a fixed flexion deformity at the distal interphalangeal joints, they are called mallet toes. Pain and discomfort over the head of the fifth metatarsal, Tailor's bunion or a bunionet.

Pinak :

Very often at the present moment because of the lockdown, I see many patients coming in with pain and discomfort in the foot, in the mid foot, usually they would have started running during the lockdown because there is nothing else to do. Their foot is put through mechanical stresses that they have not been used to and they come with something like this. Swelling, redness, pain, discomfort, painful while the bear weight, always think of stress fracture and the stress fracture of the metatarsals is common and has been quite common during the lockdown period. And if you, if you do suspect a stress fracture the first two weeks, you will not be able to see anything on an x-ray and therefore, if you have seen them early on an x-ray will not help. My advice is if you feel, and if you think that this could be a stress fracture, we send them for an MRI scan.

Steven:

Why are you saying it's been more common during the lockdown period? Why is that?

Pinak :

I only say that because there are people who have never run before, who have started running, people who've never done things that before, who have started doing things during the long run.

And that's why I feel abnormal stresses overuse for, for portions of their body that has not done the things before. That's why.

Steven:

And is that a particular age group or does it fit any sort of gender category?

Pinak :

Yeah, I think, I think it's between the thirties and the fifties up to 30 and 50 that the kind of....if someone comes with mid foot pain but they are slightly older age group, always think of mid foot arthritis, they will always come with swelling on the top of the dorsum of the foot. Direct pressure over the mid foot will be painful. Always think of an arthritic midfoot joints. You most probably will be seeing this very often. Heel pain. Now if a patient comes and says, I got heel pain, it's for us to find out where is this heel pain.

Pinak :

Deep pain in the under surface of the heel around the medial calcaneal tuberosity is almost pathognomonic of plantar fasciitis. Pain is usually early in the morning. When you take your first step, pain usually settles down when it, when it warms up. They, they definitely always have a very tight Achilles tendon and if you test it, it will be tight. They said that they have tried out, because everybody reads the internet and people find out about, about what they have and they try things. But it's for us to let them know what exactly to do and I can discuss that over the course of the next hour. If they come and say that the pain is in the back of the heel, but at the distal attachment of the Achilles tendon, then it's insertion of the Achilles tendonitis and you can see the bump and the swelling and that's called a Haglund's deformity.

Pinak :

We are Haglund's deformity is really a lump in the posterior aspect of the calcaneum pushing the Achilles tendon back using inflammation and causing pain.

Steven:

Is that called the Pump Bump?

Pinak :

Yeah, exactly the same. Well, if somebody comes and say that they have pain, discomfort and swelling in the middle of the Achilles tendon then it's non insertional Achilles tendonitis. This particular x-ray is that of a child as you can see, there's an hypophysis. Children when they come and they talk about heel pain and the pain is directly on the heel, most probably it's a Sever's disease. People may argue it's not really a pathology, but then children do come with pain and discomfort. If you take an X ray, you will see this. It's almost like an increase in density in apophysis. It is because of overuse and because of very tight Achilles tendon, and then if you test them, they will always have a tight Achilles tendon.

Pinak :

Anterior ankle impingement or anterior ankle pain, usually, athletes mostly football players or basketball players who have a continuous process of dorsiflexion and plantar flexion resulting in,

you can see these osteophyte formation in the front of the ankle, which reduces the dorsiflexion and they'll come and tell you that the pain is in front of the ankle. Think about anterior ankle impingement. If an elderly person comes and talks about swelling, pain and discomfort in the front of the ankle, most probably it's an arthritic process. Patients will come and talk to you about pain in the back of their ankle. Now you may think most probably it could be Achilles tendon, but the pain is usually, you can see the pain is usually in front of the Achilles tendon and behind the medial malleolus and the lateral malleolus. So that's a gap in between, in between the bones and the Achilles tendon.

Pinak :

And that's where they get the pain. They not only get the pain in the back, sometimes they can get a pain in their arch as well. And that's because there are tendons that cross that area and go up to the toes. Usually you can reproduce the pain by plantar flexing the ankle that can reproduce the pain. If you get an xray, they might have this kind of piece of bone called the os trigonum, very commonly seen in ballet dancers because they do this point in extreme plantar reflection and that's posterior ankle impingement pain. If the right diagnosis is made, there are very easy treatments to treat them.

Steven:

What do you think is the cause of that so you know, you'd think in a ballet dancer if you're doing lots and lots of plantar flexion, it would prevent that occurring. Is it just that they discover them more in ballet dancers or is that action producing the

Pinak :

No, I think extreme plantar flexion can cause this constant rubbing of the soft tissues. If you have a little piece of os tri going on there, then you can well imagine that those soft tissues are being pinched every time and it is an overuse injury. That means it may not happen for five years but then it happens. Most ballet dancers are very flexible and therefore and therefore they don't have the pain but when they, when they do, they don't let it settle down and because they don't let it settle down, it becomes chronic.

Pinak :

Patient will come and talk to you about pain in the lateral aspect of their ankle and generally would point towards the back of the fibula and if there is pain in the back of the fibula, most probably it's a peroneal tendon pathology. You remember there are two peroneal tendons, peroneus brevis tendonitis pain is just behind the fibula but peroneus longus tendonitis pain is usually on the lateral aspect of the foot where the peroneus longus turns around and goes underneath the foot and sometimes obviously they will come and talk about a clicking sensation and when you stress the ankle, you can see the peroneus mostly the peroneus longus tendon flipping on top from the, from the groove behind the fibula in front. Pain however, on the inner side of the ankle, most probably you'll have to think about a tibialis posterior dysfunction. Generally early on they'll have swelling, pain, discomfort and kind of an inflammatory process. Later on the inflammation settles down and the foot becomes flat and when the foot becomes, becomes flat, the heel goes into, into valgus and they get a very Plano valgus like a flat foot deformity.

Pinak :

Steve, I mean this is, this is what I wanted to start off with, is to say that certain areas of the foot, if people have pain and discomfort, there are only certain diagnoses that can be made. And I think if we have that kind of knowledge, then we can always think outside the box because not every time a medial ankle pain is a tibialis posterior dysfunction, it can be something else.

Steven:

Well, like I said at the beginning, this is, this is all very close to the hearts of osteos chiros and physios and I've had a load of questions come in while you've been talking. One, I don't have a name for this, but when you were talking about stress fractures, it's probably occurred to a lot of people since few of us have the advantage of x-rays in our clinics. What tests are reliable? Is percussion a reliable test for a stress fracture or ultra sounding it and didn't mean ultrasound scan.

Pinak :

No, I know, I know in my, in my opinion in my practice I think is direct clinical examination. Number one, you're looking for an area localized area of swelling, a localized area of redness initially and for, if you take the example of the metatarsals, it's usually the second and the third metatarsal that you have a stress fracture and it's very easy to, when you examine the patient and you press on the first fourth and the fifth, they'll not be painful. But usually the second and third are in my opinion, in my practice, I would just do a direct provocation test to see where the pain is. If you have a stress fracture of the fifth of the fifth metatarsal is very easy to diagnose a stress fracture of the distal fibula. Also very easy to diagnose that means clinically I'm talking about. And sometimes as I, as I was just mentioning, pain over the medial malleolus without any significant swelling can easily be a stress fracture. And in my practice I have seen a few especially runners.

Steven:

What about the calcaneus? I mean, I've performed the squeeze test a number of times on patients and invariably I'm wrong in diagnosing a fracture.

Pinak :

So for me, squeeze test is very pathognomonic office stress fracture of the calcaneum and we see that very often. We did not see a lot of it this year because the London marathon got cancelled because that's what, that's when we see most of them. But see as I, as I was saying, when you have heel pain, if it's in the plantar aspect, plantar fasciitis, if it's at the back, it's tendon at least tendonitis. But if you squeeze medial laterally the calcaneum and the patient has pain, in my opinion, that's very pathognomonic of a stress fracture, and I will treat them as a stress fracture. If we can't get an x-ray, I will treat them empirically as a stress fracture.

Steven:

Vanin's asked about the success of OA surgery in the foot. You've pointed, you've had a number of cases of OA that you showed up on your pictures earlier on.

Pinak :

Yeah,

Steven:

Justin share the screen while we're talking about questions.

Pinak :

Thank you.

Steven:

Yeah. So how successful is OAA surgery?

Pinak :

Just a minute please. Can you see my screen?

Steven:

I know we did. We just killed the screen I think.

Pinak :

Yeah. So the surgery for arthritis of the foot and ankle is only done for pain relief and this is after having tried everything non operative , we start with footwear modification, physical therapy, physiotherapy, osteopathy, intraarticular injections to reduce pain. If all else fails, then we go in for surgery. And surgery done for the right joints and the right reason. Success rate is about 90%. There are a few joints I would say are difficult to fuse. Number one, the tarso metatarsal joints and two the calcaeo-cuboid joint. So they are slightly difficult. Now many a times it's difficult to convince a patient to be non-weightbearing for a very, very long time. But in Europe they do it for three months sometimes. We don't do that in this country. We generally immobilize them for about six weeks. But I think those particular joints the tarso- metatarsal joint, the midfoot joint and the calcaeo-cuboid joints , if you're fusing them then I think you should immobilize them for a very long time. But these are very successful surgeries. If done for the right reason, although the patients need to be told that it can take about a year for the foot to settle down.

Steven:

Jess has asked a specific question about a patient she has. I'm reading this directly. It says she's a fit healthy lady who used to be a competitive gymnast, a recent Cartiva implant, to the hallux which has, hasn't failed, but the local area around the Cartiva has persistent pain. If the pain doesn't resolve, what are the options apart from fusion? And I have to say, I don't actually know what a Cartiva implant is!

Pinak :

The Cartiva implant is is, is made up of hydrocellulose it's a non-metallic implant that replaces the part of the head of the metatarsal. When you have an arthritic big toe joint, literature says that the results are, I would think about 70 to 80% good results. Many a times you can get chronic inflammation because of soft tissue reaction. You know, other than repeat surgery and converting it to, I mean, obviously the, the patient does not want a fusion, is that correct? Most probably

Steven:

She hasn't said that the patient doesn't want a fusion, but she's asked what the options are. Short of that,



Pinak :

The other options would be to go and debride it, clean it up, and see whether that helps. If if, however, sometimes we see in a Cartiva that the Cartiva has collapsed in that case there is no other option other than taking the Cartiva out, cleaning it up, debriding it, and then fusing it. So I think if the patient continues to get pain and discomfort and is unable to do the things he or she is doing, then I think the option only option would be to convert it into a fusion.

Steven:

I noticed on your website earlier on, I think on your Twitter feed you've said that during Covid 19 during this problem, you've been offering advice to patients with back pain and following on from what you've just said, if you fuse the hallux surely that is going to lead ultimately to an altered gait pattern which could increase people's back pain?

Pinak :

What we have noticed is this, is that when patients have a fusion of the big toe joint, let me talk to you in two parts. One part is about the foot and ankle itself from, from a situation of quite significant pain wherein, the patient has to limp on one side or maybe twist their foot to walk on the lateral side of the foot resulting in? Where once it fuses, they have no pain, and then they have no pain. They are then, then they can walk relatively normally I'm not talking about normal, relatively normally, plantigrade maybe with the right kind of shoes, in my opinion it will be better for the back pain.

Steven:

Ok. And I suppose it was actually that's quite different from a hallux rigidus, which is probably is going to be constantly irritated by gait, isn't it? As opposed to a fusion where there isn't any movement there.

Pinak :

Correct.

Steven:

Yeah. Several people have asked us about or asked you about the Haglund's deformity. Does it usually result in surgery or can it be managed by conservative treatments such as podiatry and biomechanics?

Pinak :

Yes, the first line of treatment, any first line of treatment in any foot and ankle problem is non-operative management. And for the non-operative management, what we need to do is these, if a patient comes with very, very painful Haglund's deformity, they come to your clinic very painful at that particular time you, you will not be able to do any physical therapy. They need to rest. And I think the idea of rest for a few weeks for any inflammation is extremely important. That means it can be rest in a boot in kind of an air cast boot, not doing the things that aggravate the tendon, maybe wearing a slight high heat because that reduces the tension in the tendon and that can help as well. Once the pain and the discomfort settles down, then maybe a little bit of physical therapy osteopathy for mobilization and of the tendon. That can be helpful. A little bit of ultrasound

therapy. If all else fails and you have had six months of treatment and it's still painful and still bothering the person cannot wear their shoes, then it will end up in surgery.

Steven:

Okay. And when we put people into an Aircast boot or, or any other form of brace. What sort of collateral damage occurs as a result of wearing something like that for six weeks. So there'll be some muscle wasting. But is there any other.....I think we've lost your audio.

Pinak :

The one thing we should realise is any aircast boot is very high. It's about two, three inches high. And if you don't if you don't mention to the patient to, to equalize their pelvis by raising the other side, I have known many patients coming at six weeks wanting to get rid of that boot because their back is now aching and problematic and waking them up from sleep. So I think there are shoes, there are shoes that can be bought over the net that can be put onto your shoes on the other side. Or just if I would, I would advise my patient to wear slightly higher heel on the other side because if that is one of the collateral damages is doctrine back pain.

Steven:

Okay. And when you, you've talked about raising the heel for the Haglund's deformity problem as well. That's easy in a woman, you can say wear small heeled shoes or something but with a man what sort of, we can put heel raises in those shoes, but what sort of height is necessary to relieve the stress sufficiently?

Pinak :

Just, just an inch.

Steven:

An inch. That's quite a lot. Yeah. Yeah. Okay. Justin, Justin's asked us if there are any good joint replacements for the ankle.

Pinak :

Yeah, there are many in the market at the present moment. Overall results are looking very good nowadays. It is the third generation ankle replacement. They are mobile bearing. That means you have a uncemented typical component and uncemented talar component and an immobile meniscus which is very similar to an upside down knee replacements and knee replacements have their history of 40 years, but the third generation ankle replacements about 10 years, and the ones in the market at present are doing very well. So yes, there are good ankle replacements. Now the important thing is the patient choice has to be alright in the sense choosing the right patient for an ankle replacement is very important. Ankle fusion. It has always been gold standard for arthritis and is an amazing surgery, but it has hasn't, as you mentioned Steve, it has some detrimental collateral damages because of the abnormal mobility of the foot and ankle because you can then produce arthritis in the other joints. It can then result in pain and discomfort higher up. But ankle replacement, the third generation ankle replacements are excellent.

Steven:

So which patients would you select for ankle replacement then?

Pinak :

So for me it has to be patients who have low demand. If you wanted to go and play tennis then I would not then you will not be a candidate. If you want to go and play a round of golf, then you can have an ankle replacement. So the ankle replacement you cannot have an ankle replacement if you want to if you are, if you're high demand for that, for patients like that, I think fusion is the best way for.

Steven:

So high demand meaning high impact sports or cyclists would be a good candidate then or?

Pinak :

Exactly cyclists can be a very good candidate. Because what it does with an ankle replacement is that it kind of maintains the physiological movement in the ankle, which means it means it's, it tries to maintain the heel to toe gait, which is good for overall muscle balance in the body.

Steven:

I've just been reminded by a cheeky chiropractor in our audience that actually they often do have x-ray facilities in their clinics, unlike most osteopaths, so lucky old chiropractors. ? Has asked about ATFL laxity and whether you would recommend shortening the ATFL or cabling.

Pinak :

Okay. So when a patient comes to me with ATFL laxity, their main symptom would be a feeling of instability, either a feeling of instability or every time I'm playing, my ankle gives way. When you examine the ankle and you do an anterior drawer test, you will find what we call as a suction effect. That means the fluid or the soft tissues are sucked in between the Talus and the fibula because the ATFL either is not there, torn or long and elongated if the patient. What I tell my patients is this, you do need some osteopathy, some physical therapy to strengthen up their lateral tendons. That is peroneal tendon strengthening. A general proprioception kind of exercises can help. Then I tell them that if, then I give them the example of Andy Murray who used to play tennis at the highest level with an ankle brace because he doesn't have these ankle ligaments, And if all else fails then you need surgery and the full surgery, what we do is we shorten it. We do what we call a pants over vest repair and reconstruction of the lateral ligament and then put a cable over it, which is called an internal brace.

Steven:

Okay, so would that apply to people who get frequent ankle inversion sprains for example. Do you think the proprioception training is the first course, which is what? Wobble boards and other similar stuff.

Pinak :

Correct. I think it's a loss of balance as well. And if you can do that, do the rehabilitation, do the peroneal tendon strengthening and sometimes the ankle can stabilise enough so that you don't need

chronic lateral ankle instability, but 50% can get better just with this, you know, proprioceptive exercises and strengthening and rehabilitation,

Steven:

Jane has asked what you can do for a plantar plate injury.

Pinak :

So the plantar plate injury I guess you are talking about the lesser toes or maybe even the big toe. Firstly, we've got to make a diagnosis and for the diagnosis, I think for a plantar plate injury, whenever you see say a plantar or a hammer toe, just do a Ballottement test in which You hold the metatarsal with one one hand and just lift the approximate filings up. And if you can do that and you can feel the proximal failings coming up and there is a deficiency in the frontal plate, either it's torn or it's elongated.

Pinak :

Now there are different that they initially, if you feel that the hammertoe or the CLLATO is flexible, then I don't think there is any, any indication for surgery. What you can do is maybe strap it down. There are many straps available in the market, or you can teach them how to strap with them around the toe with sticking under the, under the foot. Those are the kinds of things, but if the deformity then becomes fixed, then they need to be the need to be treated surgically. And when I do that, and I know that there has been a tear of the plantar fascia, I I tend to repair them. And the repairing is, it's not easy because of the, because of the kind of space in there. And, and therefore we always do shortening metatarsal osteotomy and the identify where the plant our plate is and then repair it to the proximal talents. And so I, in my practice has changed over the last two or three years in which I have started repairing the plantar plates. And I think that they give up better resolved for these surgeries.

Steven:

You, you mentioned there how much of his mallet toes, quarters, have you got a theory or is there any proven cause

Pinak :

Of those deformities? I tell my patients the first thing is that is bad shoes running shoes, many, many. So what happens is sometimes when you measure your shoes, we have always measured with the big toe and there are Greek feet, the feet that have long, the second and third toes. And when you have the second and third toes and you've measured your foot from the big toe, you're always reproducing of Toronto or a hammer to inside your shoes without you knowing. And over the over the next five, 10 years you start getting this deformity. Then the other of the other calls is really an alteration in the pool of between the long extensors and the long flexors and kind of weakening off the intrinsic in the, in the foot. That can be another reason why they can get these deformities and can be neurological as well. But I generally tell my patients it's it shoes, right?

Steven:

That imbalance between flexors and extensors, how does that occur?

Pinak :

So, so basically what is happening is there are three things that are working together. The intrinsic the long extensors and the long flexes. The in, in, in everything is in balance. So now the, the, the intrinsic score is an extension of the MTPJ and the proc and the proximal interphalangeal joints, your extends along extensors cause extension of the toe, the long flexors flexion of the toe. So basically what happens when they intrinsic become weak or weakness of the intrinsic muscles in between the interest in between the metatarsus, then the flex attendance they start pulling the toe down and extensor attendants are pulling the tool up and you get a claw or up or hammertoe deformity. I think fundamental to all flow or how to deformities is the weakness of the intrinsic.

Steven:

Thank you. Sue has asked about a particular patient with perennial longus tendinopathy. She says, would that increase with weight bearing? A patient says the pain started recently in the morning and gets worse. It seems to get worse with weightbearing. She suspects that's what it is.

Pinak :

So perinatal tendon apparently his longest tendonitis generally happens where the tendon turns around under the cuboid and goes out under the, under the foot and gets attached to the base of the first metatarsal. So it usually happens on the outer side of the foot. Now patients with the parallel tendon pathology will say when they wake up in the morning, they have more pain, but when they start weight bearing, their pain reduces because the pain is usually pain usually comes about when the foot inverts, when the foot is planted grade, they will not get the pain and maybe the pathology could be different.

Steven:

And Keith sells, whether you, you think there's been an increased incidence of dropped arches and OAA given the apparent increase in obesity in the population and how the two connected I suppose

Pinak :

Drop Dodge and, sorry,

Steven:

Dropped arch and osteoarthritis.

Pinak :

I mean, I've been doing this for 15 years. I've not seen that up. I've not seen a steady increase, but the numbers are quite significant for both drop torches because we see quite a significant amount of tibialis posterior dysfunction syndromes. Which come from all stages, from stage one to kind of stage four and, and significant amount of arthritis. But I think sometimes it, it can be related to obesity. Although I've w I've seen them steadily in my practice, not an increase.

Steven:

Okay. Karen's asked, what do you think about cortisone injections, either long term or short term? Are they useful or are they detrimental?

Pinak :

And in my practice I've always given cortisone injections. Now I think for a short term it's an excellent solution. I also think as you know, during the covert period during the lockdown we have been asked not to give steroid injections because it reduces immunity and, and cause and can cost increase your susceptibility to covert. But before that, my practice has, has been a lot of cortisone injections, especially for midfoot joints. The mid foot John cortisone injection is a blessing from, from nine out of 10 pain patients will come down to one out of 10 pain and they will, they will thank you forever. Yes, it's temporary, but for that particular time they have, you're looking at between six weeks and six months, they have significantly low amount of pain and therefore more mobility and more movement resulting in better stability and may even take away the, the kind of pain that they had and may not need anything. So I have noticed in my practice, just by giving one injection or maybe following it up with another injection, some patients have not needed surgery. So in my opinion, sort of injections are excellent for the soft tissues. For example, the Achilles tendon. I would I would personally not do them. I always send it to my radiologist to do them out song guided. But for the, for, for the tendance, I generally try not to give them any steroid injections.

Steven:

Okay. Elvina is asked about Bunyan operations and why they don't always work and why a Bunyan returns within about six months with some patients to the level it was before or worse. And actually I'm curious as to know what's the current approach to Bunyan surgery. What do you do to relieve them?

Pinak :

Okay. so bundled surgery can be done in two ways. One is open surgery and the other percutaneous surgery, I'm a surgeon who does open surgery and there are many of my colleagues who will be doing percutaneous. The time of recovery is exactly the same as for both. Yes, one has tiny, smaller scars, but after some time actually you cannot see scars anyway. So the whole idea of Burundian surgery is is expectations I think. I think the expectation is, is very important up front. You have to tell the patient that this surgery is not always successful. However, my opinion, nine out of 10 patients are happy the way we do it nowadays. General anaesthetic. We do a metatarsal or store for me to shift the head of the metatarsal and then almost 95 cent times I would do a felon jail, proximate Fallon's, Fallon yellow stop for me as well to fix it, to correct it. And then we release the soft tissues on the lateral side and we apply Cate the soft tissues on the inner side. Now why, why, why does, why does it recur? No. Sometimes it can be

Pinak :

The surgery itself, sometimes it can be the screws that back out and, and, and you know, sometimes is inadequate post-op post or kind of care and recovery. And I just have a feeling maybe for the first six weeks patients should have a weight relieving shoot for about four up to first six weeks. They should have a splint that, that, that keeps the toe in the position that you want to because all the soft tissues do have a kind of a memory and they are, they can go back to where the world. But I disagree that Burundian surgery always recurs and, and, and gets worse because I mean I would think about 90% are happy. Okay.

Steven:

We're, we're almost done. We are out of time. Actually. Can I ask one more question, which is about footwear. One viewer has asked about the apparent drive in primary schools to get kids wearing Plimsouls, which have no arch support. Someone else has asked about whether flip flops are having an effect. And there's a lot of interest in the, the effect of barefoot shoes on people's foot mechanics and so on. Do you think that those unsupportive shoes are likely to have a detrimental effect or the barefoot shoes might,

Pinak :

Particularly in children? I guess in my opinion, the, the, this one of the 10 shoes that the school children are wearing nowadays are completely detrimental to, to their foot in the, for the future. And I think, I think supportive shoes are very, very important, especially in the Scully during the skeletal maturity, which is up to 14, 15 years of age. Even after that, you know, are the boots are of some or, or those kinds of shoes? I think, don't tell, I understand that there has been a vote for the the barefoot, the barefoot Walker. I don't have any, a lot of experience in that one. But there are people who say that foot pain went away, but varying, you know, that kind of shoes. But in my opinion, a supportive shoe is bought. I would advise my patients to wear, have children today.

Steven:

Thank you for that. That must 45 minutes. It's flashed by very quickly though. So very kind of give up your time, especially when you're clearly back to being very busy and in surgery and clinic again. And I'm sure that you've answered an awful lot of people's concerns about foot and ankle problems. So thank you very much for joining us today