AMIT AMIN
FOOT & ANKLE SURGEON

Hammer Toe Correction

The exact procedure chosen to correct your hammer toe will depend on the detailed examination performed at your out patient assessment.

The following factors will be taken into account:

A. Location of the deformity
B. Flexibility of the deformity (how supple it is)
C. Underlying cause

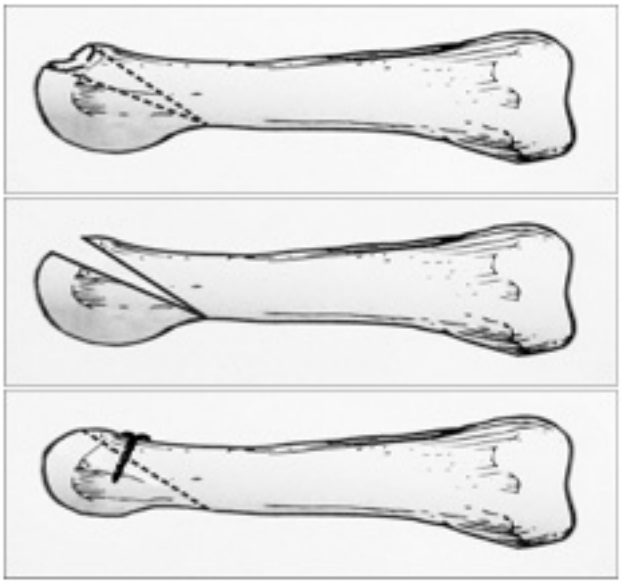
The most common procedure is a FUSION of the first joint in the toe. This is often coupled with release of the tight tendons and any other structures, which hold the toe up in the deformed position. To accomplish this, a small incision is required over the top of the foot and over the first joint in the toe.

Many different techniques are available to achieve a fusion. The joint is opened and repositioned straight. It is sometimes held with a wire, which points out of the end of the toe (bent over and protected), and is removed painlessly in clinic at around 5-6 weeks post surgery. I occasionally use an implant to hold the toe straight. There are many options available on the market. One option is detailed below:

http://www.dailymail.co.uk/health/article-2460212/Me-operation-An-end-misery-bent-painful-toes.html

Weil Osteotomy

Sometimes a hammer toe requires correction further back in the foot. At the level of the 'knuckles', the tight tendons are released as well as the joint lining of the MTP (knuckle) joint. Occasionally, the toe remains deformed despite this release, especially when the toe or metatarsal itself is naturally long. In this scenario, we need to shorten the corresponding metatarsal by performing a Weil osteotomy. I use a modification of the Weil osteotomy technique shown below:



What happens after the operation?

The toe correction and possible modified Weil osteotomy requires protection in a post-operative shoe for 4 weeks. The post-operative shoe allows for heel weight-bearing (walking). However, the foot must be elevated (above the heart) for 80% of the time for the first 10 days. This helps to reduce swelling and the risk of infection, and helps wound healing. Naturally, short periods of walking/standing are allowed. You will graduate into normal shoes from 4 weeks, although the swelling may still make this feel tight. From 6-8 weeks, you will be able to use regular shoes. Stiffness and swelling will usually fully resolve at around 3-6 months.

What are the risks of surgery?

Stiffness – this is common to begin and entirely expected. Early movement is key from 2 weeks post surgery, and I will instruct you in clinic.

Swelling – Initially the foot will be swollen and needs elevating. Often shoes will remain tight for 8-12 weeks. The swelling will disperse over a period of 6-9 months.

Floating toe – This is a very specific and recognised complication of hammer toe correction, especially when a Weil osteotomy is performed. When the metatarsal is shortened, this can result in a muscle imbalance, which causes the toe to sit off the ground.

Infection – You will be given antibiotics during surgery to protect you. The best way to reduce the chance of acquiring an infection is to keep the foot

elevated for 10 days. Smoking increases the risk 16 times. If there is an infection it normally resolves with a course of oral antibiotics.

Vascular (blood supply) damage – very rarely is the blood supply to a toe disrupted during surgery. If you have a very severe deformity, this increases the risk. At the end of the procedure, I will check whether the blood supply to the toe is still viable. In exceptionally rare situations the blood supply is disrupted to a point where an amputation is considered. This risk is <1%.

Nerve damage – Little skin nerves are at risk with hammer toe surgery, which can result in either a sensitive scar or permanent numbness. With scar sensitivity, regular massage often alleviates this problem. Numbness when present is not usually a problem.

Chronic Regional Pain Syndrome – This is where the nerves around the toe become overly sensitive. The area swells, changes colour and becomes stiffer than expected. It is exceptionally uncommon, but can be very debilitating. If this is diagnosed, then I will refer you to a specialist pain doctor. The outcome of surgery can be suboptimal in this situation.

Non-union – This describes the bone not healing after being re-set and fixed in its new position. Scar tissue holds the joint stable – we call this a fibrous union. Quite often a fibrous union results in no pain. Further surgery is needed if painful.

Undercorrection – Occasionally, the deformity of the toe is not fully corrected. This is more common in severe cases. The risk of floating toe as described above is also higher. Whilst the toe position will be much better, a little undercorrection is rarely problematic.

Avascular Necrosis – This is where the blood supply to the bone is disrupted, leading to the bone tissue dying and collapsing, and the joint surfaces being damaged. This can lead to arthritis (pain and stiffness), which may require further surgery.

Incomplete relief of symptoms – The majority of symptoms will be improved by this procedure. Any remaining symptoms can normally be accommodated with foot orthoses.

Deep Vein Thrombosis (DVT) – This is a clot in the deep veins of the leg and the risk of this occurring following foot and ankle surgery is low (generally< 1%). The fact that you are mobile after surgery and able to take weight through foot helps to minimise this small risk. However, it is sensible to try and move the toes and the ankle regularly following the surgery and probably also sensible to avoid a long-haul flight in the first 4 weeks following surgery. If a deep vein thrombosis (DVT) occurs then you will require treatment to thin your blood as this helps prevent any of the clot travelling to the lungs (pulmonary embolus / PE) which can be much more serious. If you develop severe pain and swelling in your calf, you should attend A+E, and inform my team.

Sick leave

4 weeks off work for sedentary jobs
6 weeks off work for standing/walking jobs
8 weeks off work for manual / labour jobs

Driving

You will be able to return to driving following the 5-6 weeks review, based on satisfactory progress.

These notes are intended as a guide and some of the details may vary according to your individual surgery.