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About Your Operation

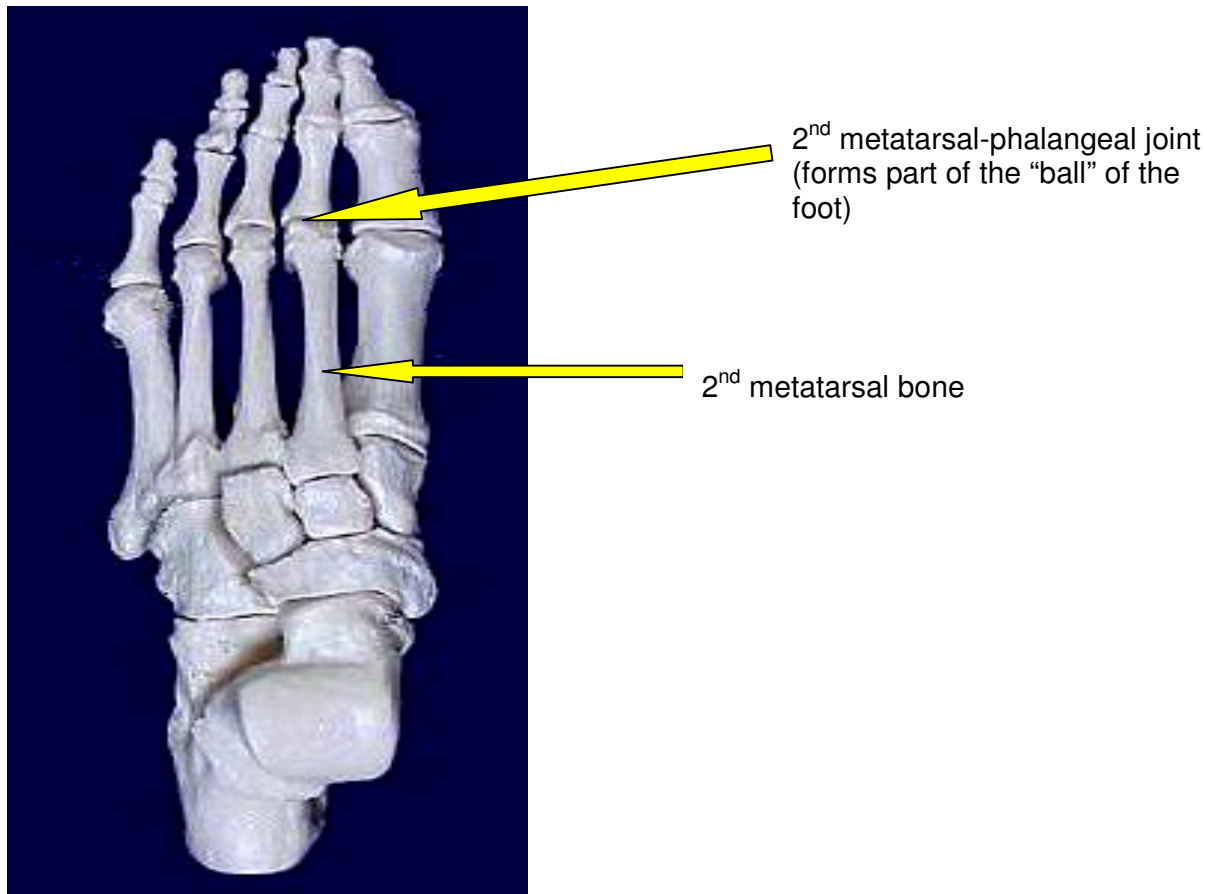
Lesser Metatarsal Osteotomies

These are performed for the following main reasons:

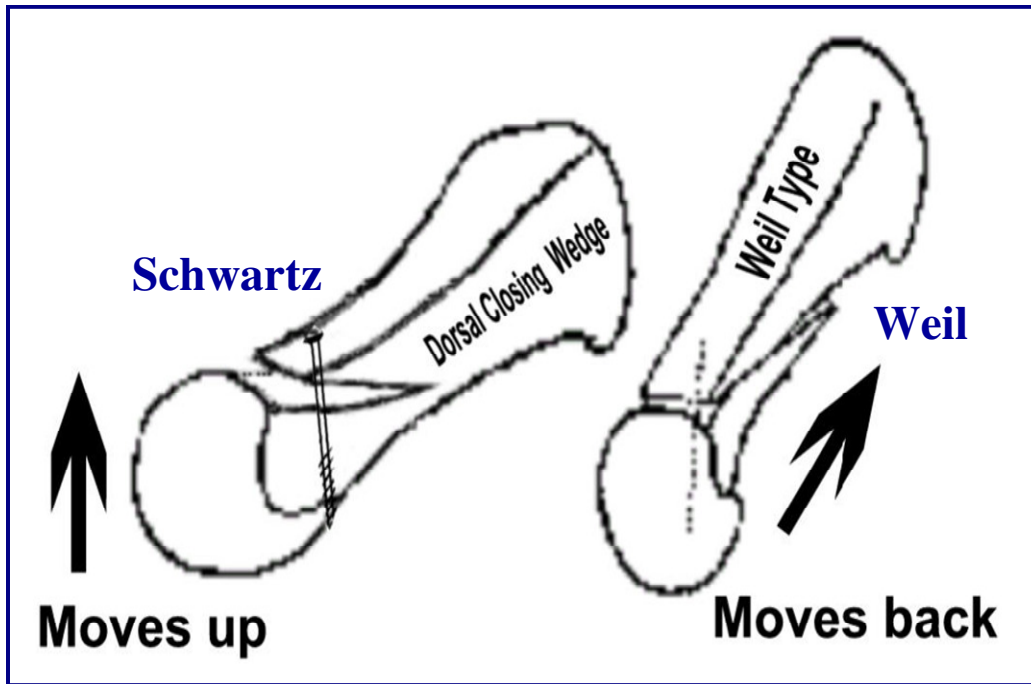
1. You have an overlong metatarsal/s, which is causing more body-weight/pressure than normal under one particular joint on the ball of the foot.
2. You have a plantar-flexed metatarsal, which means that this particular metatarsal is lower than the adjacent ones. This also causes more pressure than normal under the joint and often results in a painful callous or corn, and or an inflamed joint capsule (synovitis or capsulitis).
3. You have a dislocated hammertoe which needs to be repaired by pinning the toe and shortening the metatarsal to relax the joint and allow the joint at the base of the toe (metatarsal-phalangeal joint), to be realigned.

If you have tried orthoses (insoles); cortisone (steroid) injection/s and removal of the painful callous/corn and you are still in pain, then you may be a good candidate for this surgery.

The diagrams below will help you understand the types of surgery that can be undertaken:



The Schwartz and Weil osteotomy procedures are undertaken to either lift or shorten the affected metatarsal bone.



These 2 procedures can also be used in combination to both shorten and lift the metatarsal bone; this is termed a “Schweil” procedure.



The metatarsal to the 2nd toe was shortened here to help with correction of this dislocated (subluxed) hammertoe.

Potential Risks and Complications

This information is provided so that you can make an informed decision over your treatment; it is not designed to frighten you as it should be remembered that the overwhelming majority of our procedures are very successful and all complications are treatable. Your surgery carries the following *unlikely* but *possible* complications:

Infection, (approximately 2% risk). The vast majority of these are soft-tissue infections, treatable by antibiotic tablets as an outpatient. Bone infections are very uncommon, but would require hospital admittance for treatment.

Severe pain only occurs in around 7% of cases in the first 24 hour period. We use a combination of local anaesthetic techniques and compound analgesics, which is usually very effective. Rarely, patients can develop Complex Regional Pain Syndrome (cause unknown), requiring specialist treatment at a pain clinic.

Swelling is common to all surgery and may take 4-6 months or longer to reduce.

Approximately 20% of cases need to have fixation (bone screws and pins) removed: although this is not actually a complication, it needs to be born in mind especially if you are a self-funding private patient.

There is a risk that the toe associated with the metatarsal will remain off the ground following surgery. Further surgery to attempt to reduce this may prove necessary. Associated corns & calluses may not resolve. Smoking may increase your risk of the surgical fracture not healing by up to 3 times that of a non-smoker.

Vein clots can occur with any lower limb surgery, but in our practice they are seen in less than 1 in 200 cases (compared with general orthopaedics where the occurrence is reported as high as 4 out of 10 cases). Vein clots, or Deep Vein Thrombosis (DVT), is more common in elderly patients, diabetics, obese patients and patients where two or more immediate family members have suffered DVT, stroke or heart attack.

Occasionally, following this surgery, you may have some increase of pressure under the joints next to the one operated on (transfer metatarsalgia); this is treatable, although surgical treatment may be necessary to shorten one or more of the adjacent metatarsal bones, to relieve the pressure.

Unsightly scarring (hypertrophic or keloid) is more common in Afro-Caribbean; Middle and far-Eastern skin-types. Scarring can be reduced by starting to use – 2 weeks after surgery – Boots scar reduction pads (£19.99) and also using an emollient cream at 4 weeks onwards, massaged into and across the scar. At 6 weeks following surgery, you may wish to use a hydrocortisone cream to massage vigorously along the scar-line twice a day for 2-weeks e.g. HC45 cream.

Recurrence or failure of surgery: there is no absolute guarantee that your surgery will be a success. These surgeries are around 70% successful. The problem/s you have with your foot means that your foot is no longer normal. It is certainly not normal to have surgery and therefore your foot cannot ever be completely normal again. Your Consultant has performed over 8000 foot and ankle procedures, and it is our hope that these experiences and skills will help to rectify your current foot problems. Occasionally, patients do not do well from surgery, for a variety of reasons, often outside of the control of the surgeon or the patient. Very rarely a patient may be left worse off after surgery; although this is extremely uncommon. In these cases further (revision) surgery may prove necessary.

Please bring this slip with you, pre-signed on the day of your procedure.

✂

Declaration: I have read and understood all the information in this leaflet (P9)

Full name: _____

Signature: _____ Date: ____/____/____

Patient

Parent

Guardian