The deformities encountered in the adult with cerebral palsy mimic those of childhood, but the size and activity level of the patient typically requires definitive correction to be carried out in one sitting rather than contemplating multiple surgeries over time. The range of deformity in cerebral palsy encompasses all potential forefoot and hindfoot deformities, although equinus is commonly a primary component. The quality of tone, hypertonic or flaccid, must be accounted for, as must the fixed or dynamic nature of the deformity. Focal dystonia is an uncommon condition that often mimics a focal form of cerebral palsy. It is believed to originate from a focal site of overreactivity in the sensorimotor cortex leading to dramatic and persistent overactivity of isolated motor units.

As in childhood CP management, fixed torsional deformities of the limb may be encountered, and the status of femoral anteversion and tibial torsion must be checked. The less common flaccid deformity provides an easier task in most cases; tendon transfers to offset the nonfunctional motor units are more likely to behave in a reliable and predictable fashion.

Involvement of the forefoot is typically manifested as a spastic hallux valgus or varus. Fusion of the 1st MTP is by far the most reliable technique for management. Botox injections may play a role in the management of mild contractures in focal dystonia of the hallux and lesser toes. While tempting, even complete tenotomies performed around the hallux and lesser toes have a tendency for recurrent deformity purely scarring of the released tendons through the sheaths and skin. For similar reasons, hammertoe corrections should consist of PIP fusion rather than resection arthroplasty in these conditions.

Involvement of the hindfoot may be manifest as either varus or valgus, and is commonly associated with equinus. Some patients with CP may dynamically demonstrate either deformity. Surgery may be indicated for three potential goals:

1. **Improved foot position for wheelchair positioning and/or transfers.** Tibiototalocalcaneal fusion or pantalar arthrodesis is most commonly indicated for these severe cases.
2. **Brace-free ambulation.** Most typical for the mild diplegic or hemiplegic with a dynamic deformity.
3. **Improving the quality or character of the brace.** For example, an ill-fit or problematic solid ankle AFO may be replaced with a springleaf or a hinged AFO with some dorsiflexion assist / plantarflexion stop following surgery. This can represent a dramatic improvement in quality of life although the patient is still not brace-free. It should not be underestimated as a surgical goal.

Equinovarus is a common deformity most noted for tonic contracture of the posterior tibialis and gastrocnemius. This is in distinction to the overactivity of the anterior tibialis often seen in the patient after stroke. Transfer of the posterior tibialis to the central midfoot (e.g. the 3rd cuneiform or lateral aspect of the navicular) combined with an Achilles lengthening removes the deforming force and allows for dorsiflexion. While the muscle remains hypertonic after transfer, in this location it does not result in dramatic foot deformity.

The dynamic and variable nature of many foot deformities in CP indicates that a triple arthrodesis may be most reliable means of achieving a lasting result even when the deformity remains somewhat correctable passively. The relaxed state of the foot under anesthesia is deceptive; the deforming tendon forces should be released or transferred. Typically this involves the posterior tibialis in a varus deformity or the peroneals in a valgus deformity. Further deformity in the ankle or midfoot may result if this is not performed.