THEN AND NOW SESSION 3: Adolescent Bunions

7:15 – 7:35 am

Adolescent Bunions: Then: 1969

Presenting:
Andrea Cracchiolo, III, MD
Los Angeles, California

ADOLESCENT HALLUX VALGUS (AHV) THEN (1970)
In the early ‘70s, in the Los Angeles Area, surgery for AHV was discouraged. This may have been because of social and cultural factors. Patients were almost always asymptomatic, there were few orthopaedic surgeons specializing in foot/ankle, instruments and internal fixation were sub optimal. However, even today it is most unusual for this group of girls to be operated upon. INCIDENCE; Hardy/Clapham (JBJS B 1951, Piggot (JBJS B 1960) and Helal (CORR 1981) all noted the deformity before age 20.
CONSERVATIVE CARE: Patience from the child, Courage from the MD, parents, and grandparents. Shoe modifications only.

Adolescent Bunions: Now: 2009

Presenting:
Martin Sullivan, MD
Sydney, Australia

The Juvenile Bunion - Now 2009
The prevalence of Hallux Valgus or Juvenile Bunion in children between 7-10 years old is 2%, and 3.5% in adolescents aged 13-16 years old. Juvenile Hallux Valgus deformity can occur before the age of 10, in up to 40% of cases reported.
The majority of cases affect females (85% or greater) and are bilateral. A positive family history has been reported in 72% of cases. Ill fitting shoes play a minor role in the etiology of the condition. Pes Planus is not a risk factor in the occurrence of this condition, whilst metatarsus adductus is associated with the condition.
AP & Lat weight bearing radiographs are taken to determine the hallux valgus angle, the 1-2 intermetatarsal angle, the length of the first and second metatarsals, the metatarsus adductus angle, and the proximal and distal metatarsal articular angle.
A long first metatarsal can be significant if associated with increased angulation of the distal metatarsal articular angle (DMAA).
Surgical correction of a JHV can be performed with an open epiphysis and is not contra indicated, although there has been a report of a higher complication rate in this group. Lateral hemiepiphyseodesis of the great toe metatarsal has been reported with a favorable outcome.
The recurrence after surgery is 10%. Post op stiffness of the joint is not a significant problem, however can occur after this type of surgery. Selection of the most appropriate surgical technique is based on the severity of the deformity, x-ray findings, and the surgeon’s skill and expertise. Isolated soft tissue procedures for this condition frequently fail. Surgical procedures which shorten the first ray, or dorsiflex the metatarsal head, should be avoided. A combination of a distal soft tissue procedure, and first metatarsal osteotomy (single or double), are associated with good or excellent results. This presentation highlights the recent reported results of surgery performed for this condition.