Surrey Total Health

Your Health. Our Reputation.

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Edition 2

Monthly Educational Topic

Each month our newsletter will provide you with information from one of our clinicians on a topic we hope you will find useful and informative. The topic this month is on Metatarsalgia written by Arshad Khaleel our Orthopaedic Clinician.

Editors:
Mr Josh Jacob & Dr Ashwin Unnithan

Welcome

Welcome to the new **Surrey Total Health** newsletter for our local GP's. **Surrey Total Health** are a consortium of clinicians working in the Surrey and outer London region to support GP practices with educational events, talks within your practice, materials and referrals for your self-paying and insurance patients.

Our aim is to ensure we can provide care for almost any condition. With some of the UK's leading clinicians at our disposal, we're almost certainly able to help you and your family. The practice areas we cover are wide and varied - from head to toe and from old to young.

Arshad Khaleel

Orthopaedics

Mr Khaleel graduated in 1989, completed Basic Surgical Training in London and Higher Surgical Training in Trauma and Orthopaedics on the SE St Thomas and Guys rotation. He obtained an MSc from the University of Dundee in Trauma and Orthopaedic Rehabilitation and Technology. He was appointed as a Consultant at Ashford and St Peter's Hospital in 2002.

As an Orthopaedic Clinician he is able to diagnose and manage a wide range of conditions including **Hip pain, Hip arthritis, Hip replacement surgery, Knee pain, Knee arthritis, Knee arthroscopy (keyhole surgery), Knee replacement surgery, Foot pain, Foot arthritis, Ankle pain, Ankle arthritis, Ankle arthroscopy (keyhole surgery), Bunion surgery, Achilles Tendon, Ankle instability, Heel pain/plantar fasciitis, Morton's Neuroma, Osteotomy, Limb lengthening, Deformity correction, Tendon surgery, Fractures, Stress fracture, Ilizarov fixator.**

Multi Disciplinary Team

Surrey Total Health has a 4 member Orthopaedic group covering all aspects of trauma and Orthopaedics, including spine. Their combined expertise is in excess of fifty years experience.

We also discuss complex patients with our Pain and Rheumatology team. We work with the top rehabilitation and physiotherapists in Surrey and pride ourselves on giving patients rehabilitation based on their individual needs. We work with Gold Medalist UK Athletes.

To see the full list of our specialities visit our website www.surreytotalhealth.co.uk

Metatarsalgia

Metatarsalgia or pain in the ball of the forefoot is an extremely common condition. In the majority, the pain is mild and temporary; it improves with rest, massage and simple footwear modifications. Symptoms that persist despite these measures may be associated with pathology and thus an assessment of aetiology and appropriate treatment becomes necessary.

Risk factors associated with Metatarsalgia

- **Activity** prolonged periods of standing; frequent running/high impact exercises
- **Footwear** narrow court shoes; high heels
- **Age and weight** loss of plantar fat pad; obesity
- **Calf tightness**
- **Foot shape** high arch foot; hallux valgus
- **Local and systemic inflammatory pathology** OA; RA; gout

Topic continues...

Assessment of Metatarsalgia

History of risk factors
It is important to identify some of the risk factors in the patient's history particularly of activities and footwear choices. Often there is a combination of problems such as standing for long periods in narrow footwear. The intensity and frequency of activities may be explored.

Clinical examination
The foot may be entirely normal to look at but a systematic examination may aid diagnosis.

- **Look** shape of foot for deformity, particularly of the toes; plantar callosities (overload)
- **Feel** metatarsals for tenderness, sesamoids; joints for swelling (inflammation)
- **Move** ankle joint range of movement; MTP joints; long tendons (tight calf)
- **Provocative test** Mulder click for Morton's neuroma
- **Investigations** X-ray; MRI scan is the 'gold' standard for investigating metatarsalgia as it can demonstrate bone, joint and soft tissue pathologies

Management

Assess risk factors and offer appropriate advice particularly about activity modification and weight e.g. leisure running may be done with breaks, on softer ground and with cushioned trainers.

- Optimise systemic medical problems such as inflammatory pathologies
- Simple Footwear choices/adjustment: cushioned, wider fitting shoes and trainers.
- Exercises for calf stretching
- LA injections are helpful for inflammatory conditions such as hallux rigidus and Morton's neuroma
- Consider referral if no response

Take Home Messages

Metatarsalgia is a common symptom. The majority of patients have mild symptoms which should respond to footwear and activity modifications as well as calf stretching. Consider weight loss if appropriate.

Please refer to question number 3

Questions

For a chance to win a £50 Amazon voucher answer these questions here - www.surreytotalhealth.co.uk/metatarsalgia-competition

1) A 22 year old marathon runner developed pain in her forefoot during training. She does not recall an injury and there is no swelling. She is medically fit. The pain has worsened and now she has intermittent pain on walking. Clinical examination was unremarkable. An X-ray was reported normal. What is the most likely diagnosis?

a. Frieberg's infarction
b. Morton's neuroma
c. Plantar Fasciitis
d. Stress fracture
e. Tendonitis

2) What investigation may you request for the above patient?

a. USS scan
b. MRI scan
c. CT scan
d. DEXA scan
e. None of the above

3) A 45 year old lady has a 2 month history of increasing forefoot pain associated with numbness and tingling of the 3rd toe. She is otherwise well. See the clinical photograph of the foot. What is the diagnosis?

a. Hallux Valgus
b. Bunion
c. Morton's Neuroma
d. Transfer Metatarsalgia
e. All of the above

4) Which of the following patients with type 2 Diabetes mellitus is most likely to develop a foot ulcer?

a. 54 yr old female unable to feel her plantar aspect of foot
b. 51yr old male with ratio of ankle to brachial pressures of <0.6
c. 71 yr old male with serum albumin of 3.1g/dl
d. 60 yr old with autonomic dysfunction leading to dryness of skin due to anhidrosis
e. All of the above