



Introduction

Foot and ankle arthritis can cause pain and immobility. The most common type is osteoarthritis, generally known as a wear and tear of the joint. It commonly occurs in people above 60 years of age. In the younger population it can be due to trauma or inflammatory joint disease (such as rheumatoid arthritis).

When non-operative methods of treatment fail to control the pain, then fusion can be used to correct severe deformity in the foot and ankle, e.G. Flat foot, high arches. Fusion of a joint requires a surgical stiffening of the joint.

When is it Done?

When non-operative methods of treatment fail to control the pain, then fusion surgery can be considered. This involves removing the damaged joint surfaces and holding the bones together until they fuse. Sometimes, before considering fusion, your surgeon may offer to inject steroid and local anaesthetic into the joint to see whether this helps the pain. In some cases, this relieves the pain and surgery is not necessary. In others, pain relief is not permanent, but the result of the injection helps the surgeon to decide which joints to fuse.

Surgery

ANKLE FUSION

This involves a cut on the outer side of the ankle. The lower end of the fibula bone is removed and used for bone grafting. The damaged joint surface is removed to allow the two bones to heal together. The bones are held rigidly together by screws.

FOOT FUSION

The location of the cut depends on the joint(s) to be fused. It may involve one or more cuts. The joint is opened up and the joint surfaces are removed. If necessary, it may be re-shaped to correct a deformity. The joints are then put in the correct position and fixed together with screws, pins, staples, plates or a combination of these. It may be necessary to use some bone graft to supplement the fusion. This extra bone may be taken from the heel bone (calcaneus), shin bone (tibia) or pelvic bone (iliac crest).

Some people with foot deformities have tight Heel cord (achilles tendon). This may need to be lengthened during surgery by making three small cuts in the calf and stretching the tendon.

Before Surgery

Your surgeon will undertake a thorough history and examination of your problem. Your surgeon will undertake a number of tests to

ensure that you are suitable to undergo surgery. You will require blood and urine tests, chest x-ray and an ecg (heart tracing). You may require a prior meeting with your anaesthetist for further assessment. Anti-inflammatory medications such as aspirin, brufen, voltaren, etc. Should be stopped 10 days before surgery. If you are taking any blood thinners, for example, warfarin, plavix or iscover, stopping these should be discussed with your surgeon. It is ideal if smoking can be ceased prior to surgery.

It is also advisable to prepare circumstances at home prior to your surgery, as there will be a period of recovery and rehabilitation following your surgery. Arranging for family and friends to assist you in the home setting is highly recommended. You should ensure that there is adequate clearance in the home to enable you to use crutches or a wheelchair.

It is important that you organise family and friends to assist you with transport, as you will not be able to drive for at least 3 months.

After Surgery

After surgery, you will be in a plaster slab from the knee to the toes. This may be replaced by a boot later. Weight bearing is not allowed through the operated leg. Your mobility will be limited by swelling and discomfort. It is important that you rest in between walking to allow the pain and swelling to settle. At home, initially walking is kept to a minimum. You will require assistance with household chores such as cooking and cleaning.

After three months the boot is removed, it may take another 2 weeks to be comfortable in closed shoes.

Driving is not allowed when in the boot, but may be resumed when comfortable, particularly when you are able to brake in an emergency, usually after the 3 month mark following surgery.

Returning to work can be dependent upon the activities of your employment, but is usually resumed at anywhere between 6 weeks and 3 months following surgery.

Risks of Surgery

Risks include infection, wound healing problems (especially in those who smoke, have diabetes or vascular disease) the surgery may not completely remove pain or deformity. The joint may fail to fuse (non-union), which may require the surgery to be repeated. Nearby joints may wear out requiring further surgery. There are also the risks of blood clots (deep vein thrombosis and pulmonary embolism), damage to nerves and blood vessels leading to numbness.

After Surgery Timeline

3 MONTHS TO BE **fair**

6 MONTHS TO BE **good**

12 MONTHS TO BE **right**