



Opinion Article

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Hallux Rigidus: Position Paper on Treatment

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Introduction

Hallux Rigidus means that there is joint limitation of the first metatarsal phalangeal joint to a degree of 30 degrees dorsiflexion motion or less non-weightbearing or 10-15 degrees or less weightbearing standing or walking. Hallux Rigidus is normally associated with significant arthritic changes in the first metatarsal phalangeal joint. These joint arthritic changes can develop from old trauma (stubbing of toes, etc) or long standing microtrauma at the joint level (from a long first metatarsal, metatarsus primus elevatus, or severe over pronation) eventually leading to observable joint changes. These joint changes can be spur formation, joint narrowing, and other signs of cartilage loss. When a patient presents with pain in the big toe joint, in the present of a joint arthritic condition, too often the first treatment is surgical fusion. Surgical fusion of the first metatarsal phalangeal joint is typically permanently successful in eliminating pain in the big toe joint but opens the door for devastating problems in the foot, ankle, and above (at least into the low back). Patients being worked up for first metatarsal phalangeal joint fusions should be told the potential negative effects on the rest of the body and be given full availability to all of the conservative and surgical treatments to the big toe joint. The surgical procedure of total fusion of the first metatarsal phalangeal joint is on the up rise in utilization in medicine. Follow up on the patients undergoing this procedure needs to look at so much more than just pain reduction at the big toe joint level. These follow-up screenings should look at the presence of new pain syndromes developing after the patient begins to walk again over the next 5 years.

When surgery is contemplated for hallux rigidus, the standard treatments of cheilectomy, joint replacements, metatarsal osteotomies, and Keller procedures should be considered even if

the expectation is that these procedures are temporary. Besides routine weight bearing x ray evaluations, MRI scans should be more routine. These MRI scans will pick up more of the 3-dimensional anatomy of the diseased joint and can lean procedure consideration potentially away from joint fusions.

When treating a patient with hallux rigidus and documented arthritic changes in the joint, conservative treatment should be done to attempt to bring the overall pain to 0-2 (VAS) routinely. This pain reduction should be both attempted to get the patient feeling more comfortable by whatever means, and then maintained as the patient's exercise program is returned to normal. It is the author's opinion that getting out of pain will allow the patient to make a more informed consent on surgery and what type to do. If the treating physician does not have the ability within their clinical setting to attempt robust conservative treatment, the treating physician should make appropriate referrals. These conservative treatments include custom foot orthotic devices, spica taping, cluffy wedges, rocker bottom shoes, bike shoes with embedded cleats, etc. No long acting "acetate" cortisone should be used to reduce pain in an arthritic joint. Icing, contrast bathing, and physical therapy to reduce joint inflammation can all be helpful at lowering the overall pain levels. It is recommended that physicians refer their patients to the Hallux Rigidus Facebook Page run by Dr Eddie Davis (<https://www.facebook.com/groups/296534574389098>) and have their prospective surgical patients talk to patients whom have had the surgery 5 years or more earlier.

As we walk, we need to bend through our big toe joint for normal push off. This allows the transfer of weight to go from one foot to another with the least stress on the body. When our

bodies are unable to bend the big toe joint after fusion, we begin to compensate in many ways. Of course, you must inform your pre-surgical patients that they made need both foot orthotic devices and rocker style shoes, like the Hoka One, for the rest of their lives. The common compensations are subtalar joint excessive supination to transfer body weight laterally with all its problems up the kinetic chain. Also, excessive out toeing enables the patient to roll through the medial side of the foot without bending the big toe joint producing abnormal forces on the arch, medial ankle, knee and hip particularly. When the patient begins to hurt their knee for example with these compensations, what orthopedic surgeon is going to take the time to figure out what the foot needs? None of them will at least before they fix the knee with another surgery.

The key points of this position paper on Hallux Rigidus Surgery are:

1. Make sure that the patient understands all surgical options

2. Make sure that the patient is given a good opportunity to get the pain down to 0-2 VAS for 3-6 months before a surgical decision is made (a good attempt at conservative treatment)
3. Make sure that the workup includes x rays and MRIs (even when the health plan does not pay for)
4. Make sure that the patient understands that if they develop pain from compensating that they may need to be restricted to certain shoes and orthotic devices for the rest of their lives
5. Make sure that patients are given the ability to talk to patients whose big toe joint fusions were over 5 years ago.

Acknowledgment

None.

Conflicts of Interest

None.